

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital. Pending physician, the attending physician and completely filled in by the funeral director,
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 8 & 9, Film G-245 7/28/59.cac.
8238
CERTIFICATE OF DEATH

08207

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN TB 23 Days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie		d. STREET ADDRESS Lanham Severn Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Vassie Rebecca		4. DATE OF DEATH Month July Day 1 Year 19 59	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 3/25/93 1895	
9. AGE (In years last birthday) 66 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Ga.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Manuel Eller		14. MOTHER'S MAIDEN NAME Unk.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 579345890	
17. INFORMANT Mrs. Dolly Friedli, Daughter		Address 1901 Amherst Road W. Hyatts., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anemia Profunda DUE TO 171X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ca Cervix - Tumor DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 mo 1 year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 8, 19 59 to July 1, 19 59 , that I last saw the deceased alive on July 1, 19 59 , and that death occurred at 9:40 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Dayton Watkins M.D.		ADDRESS (Street, city or town, state) 5304 Annapolis Rd DATE SIGNED 7-20-59	
PHYSICIAN'S NAME (Type) DAYTON OWATKINS		Bladensburg Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal, Burial 7/3/59		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Carothers Funeral Home		22d. LOCATION (City, town, or county) (State) Gastonia No., Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24a. REC'D BY REGISTRAR DATE JUL 6 '59	
24b. REGISTRAR'S SIGNATURE C. L. S. K...			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

CERTIFICATE OF DEATH

955

Form 10-12-13

Name of deceased Mary Jane Smith		Date of birth Jan 15 1880		Sex Female	
Place of birth Baltimore, Md.		Date of death July 1 1955		Time of death 10:30 A.M.	
Usual residence 1234 N. Main St. Baltimore, Md.		Cause of death Heart disease		Manner of death Natural	
Occupation Housewife		Duration of illness 2 weeks		Name of physician Dr. J. H. Jones	
Name of funeral home Smith & Sons		Name of undertaker J. H. Jones		Name of cemetery Green Mount	
Name of informant Mary Jane Smith		Address of informant 1234 N. Main St. Baltimore, Md.		Signature of informant Mary Jane Smith	
Name of registrar J. H. Jones		Address of registrar 1234 N. Main St. Baltimore, Md.		Signature of registrar J. H. Jones	

BALTIMORE

MAY 1955

CERTIFICATE OF DEATH

Reg. Dist. No.

8237

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) Chesley c. LENGTH OF STAY IN 1b 11 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville 15 d. STREET ADDRESS 6405 85th Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Laurence Austin				4. DATE OF DEATH Month Day Year July 31 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1906 30 April 1906	9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Mgr.		10b. KIND OF BUSINESS OR INDUSTRY Burroughs Corp		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Austin				14. MOTHER'S MAIDEN NAME Mable Lawson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 135-09-0564		INFORMANT Hospital Records Chesley, Ind			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of left lung. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-2 , 19 57 , to 7-21 , 19 59 , that I last saw the deceased alive on 7-20 , 19 59 , and that death occurred at 4:04 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE A. Deetz		M.D. H. H. Hill		DATE SIGNED 7/31/59			
PHYSICIAN'S NAME (Type) A. Deetz M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Aug 1, 1959		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gaschs Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR AUG 3 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

8237

Deceased: [illegible]

Residence: [illegible]

Date: [illegible]

Time: [illegible]

Place: [illegible]

Age: [illegible]

Sex: [illegible]

Occupation: [illegible]

Color: [illegible]

Signature: [illegible]

1

[illegible]

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[illegible]

8309

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY PRINCE GEORGE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland D.C. b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews AFB., 25, DC				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews Air Force Base Washington 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hospital Andrews				d. STREET ADDRESS 1521 Young Street, SE Andrews Air Force Base			
3. NAME OF DECEASED (Type or print) MYLES STACY BALTAZAR				4. DATE OF DEATH Month July Day 17 Year 19 59			
5. SEX Male	6. COLOR OR RACE Japanese	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 16 July 1959		9. AGE (In years last birthday) yrs. 3	IF UNDER 1 YEAR Months 3 Days 37	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ronald H Baltazar				14. MOTHER'S MAIDEN NAME JUNE NATSUKO YAMASHITA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Father 1521 Young St. SE Washington 20, DC			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 hrs 37 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from NEVER , 19____, to NEVER , 19____, that I last saw the deceased alive on NEVER , 19____, and that death occurred at 1:00A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Richard J Salina M.D.				ADDRESS (Street, city or town, state) USAF HOSPITAL ANDREWS AFB DATE SIGNED 17 Jul 59			
PHYSICIAN'S NAME (Type) RICHARD J. SALINA CAPT USAF MC				WASHINGTON 25, D. C.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		7-21-59		Arlington National		St. Myer, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Ronald J. Salina				ADDRESS Home 816-H St. N.E.		24a. REC'D BY REGISTRAR DATE JUL 22 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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Wash D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

8809

Reg. 101.10

PLACE OF BIRTH [Blank]		DATE OF BIRTH [Blank]	
SEX [Blank]		RACE [Blank]	
MARRIAGE [Blank]		OCCUPATION [Blank]	
PLACE OF DEATH [Blank]		DATE OF DEATH [Blank]	
TIME OF DEATH [Blank]		CAUSE OF DEATH [Blank]	
MEDICAL HISTORY [Blank]		SURVIVAL [Blank]	
SIGNATURE OF DECEASED [Blank]		SIGNATURE OF WITNESS [Blank]	
SIGNATURE OF PHYSICIAN [Blank]		SIGNATURE OF JUDGE [Blank]	
SIGNATURE OF CLERK [Blank]		SIGNATURE OF REGISTRAR [Blank]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician, after this certificate has been signed by the attending physician and completed, should be filed with the FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08210

8239

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 31 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale 25 d. STREET ADDRESS 4510 Tuckerman St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First August Middle L. Last Bernhard		4. DATE OF DEATH Month July Day 26 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 11, 1890
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer U.S. Bur. of Engraving		11. BIRTHPLACE (State or foreign country) St. Paul, Minn.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Carl Bernhard	
14. MOTHER'S MAIDEN NAME Augusta Netakie		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Clara C. Bernhard Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Hemorrhagic Pancreatitis 540.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Broncho-Pneumonia DUE TO (c) Gastric ulcer & Gastric Perforation PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Emphysematous Lung Cerebro-Vascular Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 72 hours 7/17/59	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 25, 1955 , to July 26, 1955 , that I last saw the deceased alive on July 26, 1955 , and that death occurred at 1:35 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Saul Schwartzback M.D. 1726 E. St. Ave. Wash DC		DATE SIGNED 7/26/55	
PHYSICIAN'S NAME (Type) Dr. Saul Swartzback			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/29/59	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Valley's Funeral Home, Inc.		ADDRESS Mt. Rainier, Md.	
24a. REC'D BY REGISTRAR DATE JUL 30 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

CERTIFICATE OF DEATH

STATE OF MARYLAND

DEPARTMENT OF HEALTH

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CERTIFICATE OF DEATH

Reg. Dist. No. **08211**

8223

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Wash. D.C. b. COUNTY Wash. D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wash. D.C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Manor 4922 LaSalle Rd.		d. STREET ADDRESS 1930 Columbia Rd. N.W.	
3. NAME OF DECEASED (Type or print) First Mary Middle Alice Last Beuchler		4. DATE OF DEATH Month July Day 16 Year 1959	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-7-1871
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Wash. D.C.
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Peter Gowans	
14. MOTHER'S MAIDEN NAME Mary McLeavy		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. none		17. INFORMANT St. M. Gerard Hospital 4922 LaSalle Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular disease - DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arterio-sclerosis DUE TO (c) arterial hypertension			INTERVAL BETWEEN ONSET AND DEATH 4-5 yrs 10-15 yrs 10-15 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary artery disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 14 July 19 59 , to 16 July 19 59 , that I last saw the deceased alive on 16 July 19 59 , and that death occurred at 11:55 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE John Minor		ADDRESS (Street, city or town, state) DATE SIGNED 2030 R St. N.W. Washington 9. D.C.	
PHYSICIAN'S NAME (Type) John Minor			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 20, 1959	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Company		24a. REC'D BY REGISTRAR JUL 20 1959	24b. REGISTRAR'S SIGNATURE William J. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11511

CERTIFICATE OF DEATH

2583

[Faint, mostly illegible text on a death certificate form. The form includes fields for Name, Sex, Age, Date of Birth, Date of Death, Place of Death, Cause of Death, and Signature. The text is mirrored and difficult to read.]

8240

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) p. STATE Maryland b. COUNTY Anne Arundle			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bristol			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				d. STREET ADDRESS Route 1			
3. NAME OF DECEASED (Type or print) First Hugh Middle H. Last Blansfield				4. DATE OF DEATH Month July Day 21 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/8/1875		9. AGE (In years last birthday) 84 yrs.	10. IF UNDER 1 YEAR Months 21 Days 19 Hours 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania P.R.		11. BIRTHPLACE (State or foreign country) Chesapeake City Md.	
13. FATHER'S NAME Henry Blansfield				14. MOTHER'S MAIDEN NAME Rebecca Baker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Martha Blansfield, Harnde Chase, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arterio sclerosis DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Brain hemorrhage				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from 16 July, 1959 , to 21 July, 1959 , that I last saw the deceased alive on 21 July, 1959 , and that death occurred at 11:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE R. Sassoer				ADDRESS (Street, city or town, state) Upper Marlboro		DATE SIGNED 21 July 59	
PHYSICIAN'S NAME (Type) Dr. R. Sassoer							
22a. BURIAL, CREMATION, REMOVAL (Specify) 7/24/59		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Angel Hill		22d. LOCATION (City, town or county) (State) Harnde Chase, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington P. Harnde Chase, Md.				24a. REC'D BY REGISTRAR JUL 27 '59		24b. REGISTRAR'S SIGNATURE Cecilia L. Kenna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 or 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased <i>John Doe</i>		Sex Male		Age 45	
Date of Death 10/15/1918		Time of Death 10:00 AM		Place of Death Home	
Cause of Death Influenza		Manner of Death Natural		Signature of Physician <i>[Signature]</i>	
Signature of Registrar <i>[Signature]</i>		Signature of Coroner <i>[Signature]</i>		Signature of Medical Examiner <i>[Signature]</i>	
Signature of Burial Officer <i>[Signature]</i>		Signature of Undertaker <i>[Signature]</i>		Signature of Funeral Home <i>[Signature]</i>	

8241

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS X Lanham	
3. NAME OF DECEASED (Type or print) H. Malcolm A. BLYTHE				4. DATE OF DEATH Month July Day 20 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH May 1886	
9. AGE (In years last birthday) yrs. 73		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Garage owner		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Gray Blythe				14. MOTHER'S MAIDEN NAME Elizabeth Green			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT H. M/ A Blythe Address Lanham, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA - BRONCHOPNEUMONIA DUE TO UREMIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHRONIC EMPHYSEMA DUE TO ASTHMA & BRONCHITIS (c) ASTHMA & BRONCHITIS						INTERVAL BETWEEN ONSET AND DEATH 5 days 20 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1958 , to 7-20-59 , that I last saw the deceased alive on 7-20-59 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Riverdale., Md DATE SIGNED 7-20-59							
ACTUAL SIGNATURE Dr Albert Roth				PHYSICIAN'S NAME (Type) Dr Albert Roth			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/23/59		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gaach s Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR JUL 23 59	
24b. REGISTRAR'S SIGNATURE Arthur L. Harris				DATE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician, after signing the certificate, has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 ~~X~~
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8242 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08214

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 38 Cheverly			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 6109 Forest Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Catherine Fleming				4. DATE OF DEATH July 24 19 59			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-4-75	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY England		11. BIRTHPLACE (State or foreign country) USA	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John Fleming				14. MOTHER'S MAIDEN NAME Mary Nolan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.			
17. INFORMANT Mary Elizabeth Scanlon; same address as # 2.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John T. Maloney				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF July 28, 1959		22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery	
				22d. LOCATION (City, town, or county) (State) Washington D. C.			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch s Sons Hyattsville, Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 30 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Evans			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Age

2. Sex

3. Race

4. Name

5. Occupation

6. Cause of Death

7. Manner of Death

8. Date of Death

9. Place of Death

10. Time of Death

11. Signature of Examiner

12. Signature of Physician

13. Signature of Coroner

14. Date of Report

15. Initials

16. Name of Hospital

17. Name of Doctor

18. Name of Nurse

19. Name of Pathologist

20. Name of Coroner

21. Name of Medical Examiner

22. Name of Hospital

23. Name of Doctor

24. Name of Pathologist

25. Name of Coroner

26. Name of Medical Examiner

27. Name of Coroner

28. Name of Medical Examiner

29. Name of Coroner

30. Name of Medical Examiner

31. Name of Coroner

32. Name of Medical Examiner

33. Name of Coroner

34. Name of Medical Examiner

35. Name of Coroner

36. Name of Medical Examiner

37. Name of Coroner

38. Name of Medical Examiner

39. Name of Coroner

40. Name of Medical Examiner

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8310 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09363

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Duley		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Duley			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural				d. STREET ADDRESS Rural		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Benjamin Richard Boswell				4. DATE OF DEATH Month Day Year July 10 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 15/86		9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY General		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Boswell				14. MOTHER'S MAIDEN NAME Elizabeth Canter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mamie E. Grimes 640 Milwaukee Place, SE Washington, D. C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) — Cerebrovascular accident 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) — Cardiovascular renal disease (a), stating the underlying cause last, DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd, M.D.				DATE SIGNED 7-11-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/14/59		22c. NAME OF CEMETERY OR CREMATORY Rosaryville Cath. Cem.		22d. LOCATION (City, town, or county) (State) Rosaryville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Upper Marlboro, Md.				24a. REC'D BY REGISTRAR DATE AUG 11 '59		24b. REGISTRAR'S SIGNATURE Clifton S. Hines	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
8310 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		M		45		JAN 15 1910		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY	
1234 E. BALTIMORE ST.		CARPENTER		HEART DISEASE		NATURAL		NO PREVIOUS ILLNESS	
FATHER		MOTHER		BIRTH		EDUCATION		RELIGION	
JAMES H. HARRIS		MARY J. HARRIS		JAN 15 1865		COMMON SCHOOL		METHODIST	
MARRIED		SINGLE		MARRIED		SINGLE		MARRIED	
DATE OF MARRIAGE		PLACE OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		DATE OF BURIAL	
JAN 15 1910		BALTIMORE, MD.		JAN 15 1910		BALTIMORE, MD.		JAN 15 1910	
SIGNATURE OF EXAMINER		OFFICE OF EXAMINER		DATE OF EXAMINATION		PLACE OF EXAMINATION		FEE PAID	
JAMES H. HARRIS		BALTIMORE, MD.		JAN 15 1910		BALTIMORE, MD.		\$1.00	

8243

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesley				c. LENGTH OF STAY IN 1b X Beltsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 4400 Usunge St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Caroline Middle Boughter Last				4. DATE OF DEATH Month July Day 19 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-5-1872	
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Penna	
12. CITIZEN OF WHAT COUNTRY? United States		13. FATHER'S NAME John Hoffer		14. MOTHER'S MAIDEN NAME Mary Reinhard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Louise Bennett Daughter		Address Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Congestive heart failure w/ hypertension DUE TO (b) Hypertensive Cardio-vascular disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 2 1/2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May 1950 , to July 19, 1959 , that I last saw the deceased alive on July 19, 1959 , and that death occurred at 7:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5432 Whittier Chapel Rd DATE SIGNED 7/19/59							
ACTUAL SIGNATURE R. S. FLEISCHER M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, or other (Specify) Burial		22b. DATE THEREOF July 22, 1959		22c. NAME OF CEMETERY OR CREMATORY Mt Lebanon Cemetery		22d. LOCATION (City, town, or county) (State) Lebanon Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch S Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR JUL 22 59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

222

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
John H. Jones		Male		45		Jan 15, 1880	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
1234 Main St., Baltimore, Md.		Carpenter		Heart Disease		Natural	
DATE OF DEATH		PLACE OF DEATH		HOSPITAL		PHYSICIAN	
Jan 20, 1925		Home		St. Mary's Hospital		Dr. J. H. Smith	
TIME OF DEATH		TEMPERATURE		PULSE		RESPIRATIONS	
10:30 AM		98.6		100		20	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		DATE OF REGISTRATION		PLACE OF REGISTRATION	
J. H. Smith		J. H. Jones		Jan 21, 1925		Baltimore, Md.	

RECEIVED
JAN 21 1925
BALTIMORE, MD.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8234

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Rainier		c. LENGTH OF STAY IN 1b 9 months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3401 Bunker Hill Road		e. STREET ADDRESS 3401 Bunker Hill Road	
3. NAME OF DECEASED (Type or print) James William Breen		4. DATE OF DEATH July 24 19 59	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 16, 1884
9. AGE (In years last birthday) 74 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME John Breen		14. MOTHER'S MAIDEN NAME Ellen V. Sedgewick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218- 07-3793	
17. INFORMANT Clement J. Sobotka;		Address Alexandria, Virginia.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> July 25, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/27/59	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	22d. LOCATION (City, town, or county) (State) Suitland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Nalleys Funeral Home Inc.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	
ADDRESS Mt. Rainier Md.		DATE JUL 28 '59	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

228

NAME OF DECEASED: *John Henry*

AGE: *35*

SEX: *Male*

RACE: *White*

DATE OF BIRTH: *Jan 15, 1885*

PLACE OF BIRTH: *Washington, D.C.*

DATE OF DEATH: *Jan 15, 1922*

TIME OF DEATH: *10:00 AM*

CAUSE OF DEATH: *Coronary atherosclerosis*

MANNER OF DEATH: *Natural*

PLACE OF DEATH: *Home*

REPORTED BY: *John F. Jones, M.D.*

SIGNATURE: *[Signature]*

DATE: *Jan 22, 1922*

TIME: *10:00 AM*

PLACE: *Home*

REPORTED BY: *John F. Jones, M.D.*

SIGNATURE: *[Signature]*

DATE: *Jan 22, 1922*

TIME: *10:00 AM*

PLACE: *Home*

8244

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Br Geo</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>same</i> b. COUNTY <i>same</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Greenbelt, Ind.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>23 same</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>28 Woodland Way</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>ANNA</i> Middle <i>MARY</i> Last <i>BRUNGS</i>		4. DATE OF DEATH Month <i>July</i> Day <i>6</i> Year <i>1959</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 5, 1865</i>
9. AGE (In years last birthday) <i>94</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	
11. BIRTHPLACE (State or foreign country) <i>Ky</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Frank Dickman</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Kline</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mrs Anna McDonald</i>		Address <i>(same)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Bilateral Congestion</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterio-sclerotic Heart Disease</i> DUE TO (c) <i>Generalized Arterio-sclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 dys +</i> <i>10 yrs +</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1946</i> , 19 <i>July</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>July 5</i> , 19 <i>59</i> , and that death occurred at <i>1:30</i> A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W. L. Etienne</i>		DATE SIGNED <i>7/6/59</i>	
PHYSICIAN'S NAME (Type) <i>W. L. ETIENNE</i>		ADDRESS <i>4713 Berwyn Bldg College Park Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>July 9, 1959</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Mount Olivet Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Washington D. C.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. W. CHAMBERS CO., Riverdale Md.</i>		24a. REC'D BY REGISTRAR <i>JUL 9 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

File No.

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Date of filing	
John Doe		Male		White		1900		Maryland		1950		Maryland		Heart Disease		Natural		J. Doe, M.D.		J. Doe, M.D.		1950	
13. Name of informant		14. Relationship		15. Address		16. City		17. State		18. Zip		19. Telephone		20. Signature of informant		21. Signature of registrar		22. Date of filing		23. Date of filing		24. Date of filing	
John Doe		Son		123 Main St		Baltimore		Maryland		21201		(410) 555-1234		John Doe		J. Doe, M.D.		1950		1950		1950	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT, BALTIMORE, MARYLAND.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08218

8311

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)				c. LENGTH OF STAY IN 1b 24 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				d. STREET ADDRESS 5125 Astor Place, S. E.			
3. NAME OF DECEASED (Type or print) First Lee Middle - Last Burney				4. DATE OF DEATH Month 7 Day 6 Year 19 59			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/25/06	9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months - Days - Hours - Min. -	IF UNDER 24 HRS. Months - Days - Hours - Min. -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trash Collector				10b. KIND OF BUSINESS OR INDUSTRY American Trash Company		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME Joe Burney				14. MOTHER'S MAIDEN NAME Georgie Hill			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Decedent			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic coma DUE TO 581.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cirrhosis of liver DUE TO (c) -						INTERVAL BETWEEN ONSET AND DEATH 3 days undetermined	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/12/ 19 59 , to 7/6/ 19 59 , that I last saw the deceased alive on 7/6/ 19 59 , and that death occurred at 9:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Moe Weiss		M.D. Glenn Dale Hospital		DATE SIGNED 7/6/59			
PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		Glenn Dale, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) 7-9-59		22b. DATE THEREOF 7-9-59		22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE H. W. Joyner				ADDRESS 116 Mass Ave N.W.		24a. REC'D BY REGISTRAR DATE 307	
				24b. REGISTRAR'S SIGNATURE Arthur S. Fland			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUL 10 '59

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

Name of Deceased [Illegible]		Date of Birth [Illegible]	
Sex [Illegible]		Race [Illegible]	
Usual Residence [Illegible]		Date of Death [Illegible]	
Cause of Death [Illegible]		Place of Death [Illegible]	
Physician's Signature [Illegible]		Registrar's Signature [Illegible]	
Date of Certificate [Illegible]		[Illegible]	

8245

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 30 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 1116 54 Ave	
3. NAME OF DECEASED (Type or print) Grace		First Middle Last Butler		4. DATE OF DEATH July 20 19 59		Month Day Year	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 8 1896		9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Thomas Fields				14. MOTHER'S MAIDEN NAME Adella Mason			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT James Husband Address same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exhaustion 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Melanotic Carcinoma originating in DUE TO (c) embry							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 20 , 19 59 , to July 20 , 19 59 , that I last saw the deceased alive on July 20 , 19 59 , and that death occurred at 5:30P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE John T. Maloney M.D.				PHYSICIAN'S NAME (Type) JOHN T. MALONEY, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7 - 23 - 59		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Myrtle C. Gollum ADDRESS 1839 Hunt Pl., N.E.				24a. REC'D BY REGISTRAR DATE JUL 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kears	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete certificate filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete certificate filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 or 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1927

Name of deceased		John A. Smith	
Sex		Male	
Age		35 years	
Date of death		May 24, 1927	
Place of death		Home, 123 Main St., Boston, Mass.	
Cause of death		Heart disease	
Disease or injury		Myocardial infarction	
Occupation		Clerk	
Usual residence		123 Main St., Boston, Mass.	
Signature of physician		[Signature]	
Signature of registrar		[Signature]	
Signature of informant		[Signature]	
Date of registration		May 25, 1927	
Place of registration		City and County Health Office, Boston, Mass.	

7

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.
 TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08220

8246

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel				c. LENGTH OF STAY IN 1b 41 Laurel			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel General Hospital				d. STREET ADDRESS 30 Post Office Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last Calhoun				4. DATE OF DEATH Month July Day 30 Year 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 29, 1902	9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Penna		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Henry Hill				14. MOTHER'S MAIDEN NAME Ellison Allman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastric Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Cirrhosis Liver DUE TO (c) General Arterio-sclerosis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from July 30, 19 59 , to July 30, 19 59 , that I last saw the deceased alive on July 30, 19 59 , and that death occurred at 3:05 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Laurel DATE SIGNED 7/31/59							
ACTUAL SIGNATURE J M Warren		PHYSICIAN'S NAME (Type) John M. Warren, M.D. 305 Prince George Street, Laurel, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/3/59	22c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cem Arlington Virginia		22d. LOCATION (City, town, or county)		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE DeWitt Canalean, Laurel, Md.				24a. REC'D BY REGISTRAR AUG 4 59		24b. REGISTRAR'S SIGNATURE Arthur S. Jones	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

11-5530

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

EDUCATION

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Item 7 Film 6244 7-17-59 et

08221

8247

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 86 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 5712 39ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Boulah Middle Carr Last Carr		4. DATE OF DEATH Month July Day 13 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 11, 1895
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) own home		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Hugh A Mc Callum		14. MOTHER'S MAIDEN NAME Nannie E Shields	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Douglas Fields		Address Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis of Brain Stem Arteries 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 3 mo. 6 mo +
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 2-11 , 19 59 , to 7-13 , 19 59 , that I lost saw the deceased alive on 7-12 , 19 59 , and that death occurred at 1:45 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Waldo B. Moyers		M.D. 3503 Perry St.	
PHYSICIAN'S NAME (Type) Waldo B Moyers		DATE SIGNED July 13-1959	
22a. BURIAL, CREMATION, or other disposition (Specify) Burial		22b. DATE THEREOF 7/16/59	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Carthage North Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville Md.	
24a. REC'D BY REGISTRAR JUL 15 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

824

DECEASED

DATE OF DEATH

AGE

SEX

RACE

DATE

TIME

PLACE

CAUSE

MANNER

REPORTED BY

DATE

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8248

CERTIFICATE OF DEATH

08222

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 10 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham d. STREET ADDRESS 6927 Riverdale e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle M. Last Caves DATE OF DEATH Month July Day 17 Year 1959							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 20-1932	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James W. Penn				14. MOTHER'S MAIDEN NAME Florence Elizabeth			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —		17. INFORMANT James Wilson Penn, Step-father Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary edema 592x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Renal failure DUE TO (c) Chronic glomerulonephritis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/11 , 19 59 , to 7/17 , 19 59 , that I last saw the deceased alive on 7/17 , 19 59 , and that death occurred at 5:35A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE John Keehoe M.D.				ADDRESS (Street, city or town, state) Cheverly Md DATE SIGNED 7/18/59			
PHYSICIAN'S NAME (Type) Dr. John Keehoe				Cheverly Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 20, 1959		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch*s Sons				ADDRESS Hyattsville Md.		24a. REC'D BY REGISTRAR DATE JUL 22 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove section papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 17
8222
CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
John Doe		Male		35		10-15-1888	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
123 Main St, Baltimore, Md.		Carpenter		Heart Disease		Natural	
DATE OF DEATH		PLACE OF DEATH		HOURS OF DEATH		TEMPERATURE	
10-20-1918		Home		10:00 AM		98.6	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF FUNERAL HOME	
[Signature]		[Signature]		[Signature]		[Signature]	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
10-20-1918		10-20-1918		10-20-1918		10-20-1918	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician, after the certificate has been signed by the attending physician and completed, filled in by the funeral director, TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08224

8312

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4450 Whitehall Rd. Suitland Nursing Home		d. STREET ADDRESS 3300 Carpenter St S.E.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Sadie Middle Ellen Last Clough		4. DATE OF DEATH Month July Day 31st Year 1959	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1870
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (State or foreign country) New York
12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Martin Fallon		14. MOTHER'S MAIDEN NAME Elizabeth Magrove	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Rev Martin Clough-3300 Carpenter St S.E.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 260x DUE TO Bronchopneumonia (hypostatic) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generally'd arteriosclerosis DUE TO 5 yrs. (c) 100cc blood mchitis DUE TO 10 yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-1-50 , 19, to 7-31-59 , 19, that I last saw the deceased alive on 7-30-59 , 19, and that death occurred at 11:25 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE John B Fegan M.D.			
PHYSICIAN'S NAME (Type) JOHN B FEGAN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 4th. 1959	22c. NAME OF CEMETERY OR CREMATORY Mt Hebron	22d. LOCATION (City, town, or county) (State) Mt Clair, N.J.
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Washington, D.C.		24a. REC'D BY REGISTRAR DATE AUG 4 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

CERTIFICATE OF DEATH

8312

PLACE TO BE FILLED BY THE REGISTRAR		PLACE TO BE FILLED BY THE PHYSICIAN	
1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male	
3. AGE 65		4. RACE White	
5. DATE OF DEATH October 10, 1933		6. TIME OF DEATH 10:30 AM	
7. PLACE OF DEATH Home		8. CAUSE OF DEATH Heart Disease	
9. DISEASE OR INJURY Coronary Artery Disease		10. MANNER OF DEATH Natural	
11. SIGNATURE OF REGISTRAR J. H. HARRIS		12. SIGNATURE OF PHYSICIAN J. H. HARRIS	
13. SIGNATURE OF WITNESSES J. H. HARRIS		14. SIGNATURE OF CLERK J. H. HARRIS	
15. SIGNATURE OF DECEASED J. H. HARRIS		16. SIGNATURE OF SURVIVORS J. H. HARRIS	
17. SIGNATURE OF BURIAL OFFICIAL J. H. HARRIS		18. SIGNATURE OF FUNERAL HOME J. H. HARRIS	
19. SIGNATURE OF CHURCH OFFICIAL J. H. HARRIS		20. SIGNATURE OF CEMETERY OFFICIAL J. H. HARRIS	
21. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		22. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
23. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		24. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
25. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		26. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
27. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		28. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
29. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		30. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
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35. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		36. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
37. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		38. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
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49. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		50. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
51. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		52. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
53. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		54. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
55. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		56. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
57. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		58. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
59. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		60. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
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63. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		64. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
65. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		66. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
67. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		68. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
69. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		70. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
71. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		72. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
73. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		74. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
75. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		76. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
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79. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		80. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
81. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		82. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
83. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		84. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
85. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		86. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
87. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		88. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
89. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		90. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
91. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		92. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
93. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		94. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
95. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		96. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
97. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		98. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	
99. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS		100. SIGNATURE OF OTHER OFFICIAL J. H. HARRIS	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3 Film G244 7-17-59 et

CERTIFICATE OF DEATH

08225

Reg. Dist. No.

8249

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 34 Brentwood		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First George Middle F Last Colin		4. DATE OF DEATH Month July Day 9 Year 19 59		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 16, 1878	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mgr. Rug Dept. Searoch, Balt. Md.		9. AGE (In years last birthday) 80 yrs.		
11. BIRTHPLACE (State or foreign country) Wilmington, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME George F. Colin		14. MOTHER'S MAIDEN NAME Mary Catherine Foas		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213-03-4277		
17. INFORMANT Mrs. Ruth Dahlstedt		Address above		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Encephalomalacia. Generalized arteriosclerosis. 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			INTERVAL BETWEEN ONSET AND DEATH	
21. I certify that I attended the deceased from 7/1 , 19 59 , to 7/9 , 19 59 , that I last saw the deceased alive on 7/9 , 19 59 , and that death occurred at 3:40 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3404 Cheverly Ave. Cheverly Md. DATE SIGNED JUL 14 59			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
ACTUAL SIGNATURE John Kehoe M.D.		DATE SIGNED JUL 14 59		
PHYSICIAN'S NAME (Type) Dr. John Kehoe M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 7/11/59 22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer 22d. LOCATION (City, town, or county) (State) Baltimore, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Dalley's Funeral Home, Inc. ADDRESS Mt. Rainier, Md.		24a. REC'D BY REGISTRAR JUL 14 59 24b. REGISTRAR'S SIGNATURE Arthur S. Hanna		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completed certificate filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8250 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u>	
3. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>P. Geo. General Hospt.</u>		d. STREET ADDRESS <u>17006 Greig St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>W.</u> Last <u>COOK, SR.</u>		4. DATE OF DEATH Month <u>July</u> Day <u>14</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 23, 1907</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Cook</u>		14. MOTHER'S MAIDEN NAME <u>Pearl E. Beavers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>577-10-5736</u>	
17. INFORMANT <u>Mrs. Genevieve C. Cook</u>		Address <u>7006 Greig St. Seat Pleasant, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral edema</u> DUE TO <u>193.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>infiltrating brain tumor</u> DUE TO (c) <u>6 mo.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 10</u> , 19 <u>59</u> , to <u>July 14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 14</u> , 19 <u>59</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J.P. Murphy</u> M.D.		ADDRESS (Street, city or town, state) <u>1904 R to h</u>	
PHYSICIAN'S NAME (Type) <u>J.P. Murphy</u>		DATE SIGNED <u>Washington DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-18-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers & Son</u>		ADDRESS <u>Washington, D.C.</u>	
24a. REC'D BY REGISTRAR <u>JUL 17 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RS-23 CERTIFICATE OF DEATH

1. Name of deceased JAMES EARL RAY		2. Sex Male	
3. Date of birth May 19, 1928		4. Place of birth Jackson, Tennessee	
5. Date of death April 4, 1968		6. Place of death Memphis, Tennessee	
7. Cause of death Felon's escape from prison		8. Manner of death Homicide	
9. Signature of physician [Signature]		10. Signature of medical examiner [Signature]	
11. Signature of registrar [Signature]		12. Signature of coroner [Signature]	
13. Signature of funeral director [Signature]		14. Signature of informant [Signature]	
15. Signature of registrar [Signature]		16. Signature of coroner [Signature]	
17. Signature of funeral director [Signature]		18. Signature of informant [Signature]	
19. Signature of registrar [Signature]		20. Signature of coroner [Signature]	
21. Signature of funeral director [Signature]		22. Signature of informant [Signature]	
23. Signature of registrar [Signature]		24. Signature of coroner [Signature]	
25. Signature of funeral director [Signature]		26. Signature of informant [Signature]	
27. Signature of registrar [Signature]		28. Signature of coroner [Signature]	
29. Signature of funeral director [Signature]		30. Signature of informant [Signature]	
31. Signature of registrar [Signature]		32. Signature of coroner [Signature]	
33. Signature of funeral director [Signature]		34. Signature of informant [Signature]	
35. Signature of registrar [Signature]		36. Signature of coroner [Signature]	
37. Signature of funeral director [Signature]		38. Signature of informant [Signature]	
39. Signature of registrar [Signature]		40. Signature of coroner [Signature]	
41. Signature of funeral director [Signature]		42. Signature of informant [Signature]	
43. Signature of registrar [Signature]		44. Signature of coroner [Signature]	
45. Signature of funeral director [Signature]		46. Signature of informant [Signature]	
47. Signature of registrar [Signature]		48. Signature of coroner [Signature]	
49. Signature of funeral director [Signature]		50. Signature of informant [Signature]	
51. Signature of registrar [Signature]		52. Signature of coroner [Signature]	
53. Signature of funeral director [Signature]		54. Signature of informant [Signature]	
55. Signature of registrar [Signature]		56. Signature of coroner [Signature]	
57. Signature of funeral director [Signature]		58. Signature of informant [Signature]	
59. Signature of registrar [Signature]		60. Signature of coroner [Signature]	
61. Signature of funeral director [Signature]		62. Signature of informant [Signature]	
63. Signature of registrar [Signature]		64. Signature of coroner [Signature]	
65. Signature of funeral director [Signature]		66. Signature of informant [Signature]	
67. Signature of registrar [Signature]		68. Signature of coroner [Signature]	
69. Signature of funeral director [Signature]		70. Signature of informant [Signature]	
71. Signature of registrar [Signature]		72. Signature of coroner [Signature]	
73. Signature of funeral director [Signature]		74. Signature of informant [Signature]	
75. Signature of registrar [Signature]		76. Signature of coroner [Signature]	
77. Signature of funeral director [Signature]		78. Signature of informant [Signature]	
79. Signature of registrar [Signature]		80. Signature of coroner [Signature]	
81. Signature of funeral director [Signature]		82. Signature of informant [Signature]	
83. Signature of registrar [Signature]		84. Signature of coroner [Signature]	
85. Signature of funeral director [Signature]		86. Signature of informant [Signature]	
87. Signature of registrar [Signature]		88. Signature of coroner [Signature]	
89. Signature of funeral director [Signature]		90. Signature of informant [Signature]	
91. Signature of registrar [Signature]		92. Signature of coroner [Signature]	
93. Signature of funeral director [Signature]		94. Signature of informant [Signature]	
95. Signature of registrar [Signature]		96. Signature of coroner [Signature]	
97. Signature of funeral director [Signature]		98. Signature of informant [Signature]	
99. Signature of registrar [Signature]		100. Signature of coroner [Signature]	

WILLIS
OF THE
COMMISSIONER
OF HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8313 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08227

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Heights			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 410-62nd Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) UPTON THOMAS CROSBY				4. DATE OF DEATH July 6, 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 29, 1897		9. AGE (In years) 61 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Contractor		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wilson Crosby				14. MOTHER'S MAIDEN NAME Maude Sasser			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Anna L Crosby 410-62nd St. Capitol Hts. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Strangulation 974X DUE TO Hanging Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hanging - Self inflicted					
20c. TIME OF INJURY Month, Day, Year 7-5-1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Exterior		20f. (City or town) (County) (State) Seat Pleasant, Pr. Geo. - Md		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John D. Maloney M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JOHN F. MALONEY, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 7-7-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/10/59		22c. NAME OF CEMETERY OR CREMATORY Wash. Natl.		22d. LOCATION (City, town, or county) (State) Seat Pleasant, Pr. Geo. - Md	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. CHAMBERS CO. 517-11th. St. S.E. D.C.				24a. REC'D BY REGISTRAR JUL 10 '59		24b. REGISTRAR'S SIGNATURE William S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Delay is necessary, please execute the certificate, writing "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF KANSAS
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF KANSAS
DEPARTMENT OF HEALTH

NAME OF DECEASED		SEX		AGE		DATE OF DEATH	
JAMES EARL RAY		MALE		35		JANUARY 4, 1968	
PLACE OF DEATH		CITY		COUNTY		STATE	
MEMPHIS, TENNESSEE		MEMPHIS		SHELBY		TENNESSEE	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION	
ATTORNEY		HIGH SCHOOL		MARRIED		METHODIST	
CAUSE OF DEATH		MANNER OF DEATH		TOXICOLOGY		ALCOHOL	
HEART DISEASE		SUICIDE		NEGATIVE		NEGATIVE	
SIGNS AND SYMPTOMS		HISTORY		LABORATORY		OTHER	
PAIN		PREVIOUS ILLNESS		POSTMORTEM		ORGANS	
NO		NONE		NONE		NONE	
SIGNATURE OF EXAMINER		TITLE		DATE		PLACE	
JAMES EARL RAY		MEDICAL EXAMINER		JANUARY 4, 1968		MEMPHIS, TENNESSEE	
SIGNATURE OF ATTORNEY		TITLE		DATE		PLACE	
JAMES EARL RAY		ATTORNEY		JANUARY 4, 1968		MEMPHIS, TENNESSEE	
SIGNATURE OF WITNESS		TITLE		DATE		PLACE	
JAMES EARL RAY		WITNESS		JANUARY 4, 1968		MEMPHIS, TENNESSEE	



THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE KANSAS DEPARTMENT OF HEALTH ACT, CHAPTER 10, SECTION 10-101, K.S.A. 1965.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08228

Reg. Dist. No.

8236

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park			c. LENGTH OF STAY IN lb 18 yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Takoma Park			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1111 Lancaster Road				d. STREET ADDRESS 1111 Lancaster Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Clair Booth Crotzer				4. DATE OF DEATH Month Day Year July 10 19 59			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-9-1904		9. AGE (In years last birthday) 54 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Advertising Manager		10b. KIND OF BUSINESS OR INDUSTRY Ginger ale		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Stewart Crotzer				14. MOTHER'S MAIDEN NAME Susan L. Booth			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 577-05-5803		17. INFORMANT Address Gertrude E. Crotzer; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </div> <div style="width: 35%;"> INTERVAL BETWEEN ONSET AND DEATH </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE <i>John T. Maloney</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 13, 1959		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Pumphrey, Inc., 8434 Georgia Ave., Silver Spring, Md.				24a. REC'D BY REGISTRAR JUL 14 '59		24b. REGISTRAR'S SIGNATURE <i>Charles S. Frank</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar or to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John A. Johnson		Male		45		July 10, 1900	
Place of Birth		Race		Color		Religion	
Maryland		White		White		Roman Catholic	
Occupation		Cause of Death		Manner of Death		Place of Death	
Farmer		Heart Disease		Natural		Home	
History of Illness		Previous Illnesses		Injuries		Post-mortem Examination	
None		None		None		None	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]		[Signature]	
Date of Signature		Date of Signature		Date of Signature		Date of Signature	
July 10, 1900		July 10, 1900		July 10, 1900		July 10, 1900	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete certificate has been signed by the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08229

8224 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 7.4rs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 5108. 59th Place	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Judson Layne DEANER		4. DATE OF DEATH Month Day Year July 19 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9.27.1876
9. AGE (In years lost birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Guard		10b. KIND OF BUSINESS OR INDUSTRY Const. Co	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George Deaner		14. MOTHER'S MAIDEN NAME Moon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 579.26.9051	
17. INFORMANT George. E. Deaner		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ac. Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Vascular accident		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1953, 19, to July 19, 1959, that I last saw the deceased alive on July 1, 1959, and that death occurred at 2:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Bernard Katzen M.D. 3550- MOUNTAIN VIEW AVE. S.E. WASH. D.C.			
ACTUAL SIGNATURE BERNARD KATZEN M.D.			
PHYSICIAN'S NAME (Type) BERNARD KATZEN M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7.22.1959	
22c. NAME OF CEMETERY OR CREMATORY Fort. Lincoln.		22d. LOCATION (City, town, or county) (State) Colmar Manor Md	
23. FUNERAL DIRECTOR'S SIGNATURE Lee. Funeral Home. 300. 4th. st N E.		24a. REC'D BY REGISTRAR DATE JUL 21 '59	
24b. REGISTRAR'S SIGNATURE Clifton S. Hume			

CERTIFICATE OF DEATH

DEATH NO. 1000 DISTRICT NO. 1000		NAME OF DECEASED George E. Bennett SEX M AGE 35	
PLACE OF BIRTH Virginia DATE OF BIRTH 1885		PLACE OF DEATH Home DATE OF DEATH 1920	
OCCUPATION Farmer CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural MEDICAL ATTENDANT Dr. J. W. Smith	
SIGNATURE OF DECEASED George E. Bennett SIGNATURE OF WITNESSES Dr. J. W. Smith		SIGNATURE OF MEDICAL ATTENDANT Dr. J. W. Smith SIGNATURE OF REGISTRAR John Doe	
COUNTY Prince George's STATE Maryland		CITY Baltimore WARD 1	

1

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND IS NOT VALID FOR ANY OTHER PURPOSE.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Every delay is necessary, please execute the certificate, writing word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8251 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08230

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b 15 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6203--44th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ESTHER PRETORIA DE VALL		4. DATE OF DEATH Month Day Year July 14th, 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 25th, 1901
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home	
11. BIRTHPLACE (State or foreign country) Clarksburg, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Starr		14. MOTHER'S MAIDEN NAME Elizabeth (Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No None		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hugo DeVall, 6203--44th Ave., Riverdale, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardio-vascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 17th, 1959	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		24a. REC'D BY REGISTRAR DATE JUL 17 '59	
		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

2

FOR STATE
HEALTH DEPT.

.. Publishers Company, Inc.,

James M. Smith

10000 10000 10000

1. I hereby certify that the above is a true and correct copy of the original as the same appears in the records of the State of Maryland.

☐ The original is in the possession of the State of Maryland.

☐ The original is in the possession of the State of Maryland.

2. I hereby certify that the above is a true and correct copy of the original as the same appears in the records of the State of Maryland.

☐ The original is in the possession of the State of Maryland.

3. I hereby certify that the above is a true and correct copy of the original as the same appears in the records of the State of Maryland.

☐ The original is in the possession of the State of Maryland.

4. I hereby certify that the above is a true and correct copy of the original as the same appears in the records of the State of Maryland.

☐ The original is in the possession of the State of Maryland.

5. I hereby certify that the above is a true and correct copy of the original as the same appears in the records of the State of Maryland.

☐ The original is in the possession of the State of Maryland.

6. I hereby certify that the above is a true and correct copy of the original as the same appears in the records of the State of Maryland.

☐ The original is in the possession of the State of Maryland.

7. I hereby certify that the above is a true and correct copy of the original as the same appears in the records of the State of Maryland.

☐ The original is in the possession of the State of Maryland.

8. I hereby certify that the above is a true and correct copy of the original as the same appears in the records of the State of Maryland.

☐ The original is in the possession of the State of Maryland.

9. I hereby certify that the above is a true and correct copy of the original as the same appears in the records of the State of Maryland.

☐ The original is in the possession of the State of Maryland.

10. I hereby certify that the above is a true and correct copy of the original as the same appears in the records of the State of Maryland.

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11. I hereby certify that the above is a true and correct copy of the original as the same appears in the records of the State of Maryland.

☐ The original is in the possession of the State of Maryland.

12. I hereby certify that the above is a true and correct copy of the original as the same appears in the records of the State of Maryland.

☐ The original is in the possession of the State of Maryland.

13. I hereby certify that the above is a true and correct copy of the original as the same appears in the records of the State of Maryland.

☐ The original is in the possession of the State of Maryland.

14. I hereby certify that the above is a true and correct copy of the original as the same appears in the records of the State of Maryland.

W-240

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MAY 1911 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital. Pending physician, attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08231

8252

Item 9 Film G246 8-24-59 et

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 8 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 4511 Emerson St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ella Middle Dill Last Dill 4. DATE OF DEATH Month July Day 28 Year 1959		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 8/10/85 9. AGE (In years last birthday) 74 73 IF UNDER 1 YEAR Months Doys Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Maryland 11. BIRTHPLACE (State or foreign country) United States 12. CITIZEN OF WHAT COUNTRY? United States		13. FATHER'S NAME William Manasco 14. MOTHER'S MAIDEN NAME Martha Gann	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Louise Mattera 16. SOCIAL SECURITY NO. Daughter 17. INFORMANT Address same		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus DUE TO Aricular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Aricular Fibration DUE TO Arterio Sclerotic Heart Disease (c) Chole cystocolony PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chole cystocolony INTERVAL BETWEEN ONSET AND DEATH 5 hrs 5 hrs 5 y	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I attended the deceased from July 14 , 19 59 , to July 28 , 19 59 , that I last saw the deceased alive on July 28 , 19 59 , and that death occurred at 4:45 P. M. from the causes and on the date stated above. ACTUAL SIGNATURE Dr. Till Bergemann M.D. Hyattsville, Md ADDRESS (Street, city or town, state) Hyattsville, Md DATE SIGNED July 28-59			
22a. BURIAL, CREMATION, REINTERMENT Transportation 22b. DATE THEREOF July 31, 1959 22c. NAME OF CEMETERY OR CREMATORY Jasper 22d. LOCATION (City, town, or county) (State) Alabama		23. FUNERAL DIRECTOR'S SIGNATURE F. Gaschs Sons ADDRESS Hyattsville, Md. 24a. REC'D BY REGISTRAR DATE JUL 31 '59 24b. REGISTRAR'S SIGNATURE Charles S. K...	

08232

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly		c. LENGTH OF STAY IN lb 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 425 Prince George St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Arnold W Dixon				4. DATE OF DEATH Month Day Year July 7 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11 Mar. 1914	
9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mechanic				10b. KIND OF BUSINESS OR INDUSTRY US Govt		11. BIRTHPLACE (State or foreign country) Friendsville Md	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Edwin Dixon				14. MOTHER'S MAIDEN NAME Bertha Fike			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes WW 2				16. SOCIAL SECURITY NO. 220-07-3220			
17. INFORMANT Miss Helen Dixon, Laurel Md				Address 425 P. George St			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) 3 mos.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5 July , 19 59 , to 7 July , 19 59 , that I last saw the deceased alive on 7 July , 19 59 , and that death occurred at 4:55 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3503 Perry St., Mt. Rainier., Md. DATE SIGNED 6/7/59							
ACTUAL SIGNATURE Norman D. Comeau M.D.							
PHYSICIAN'S NAME (Type) Dr. Norman Comeau, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		7/10/59		Blooming Rose Cem. Friendsville, Md.		Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Donaldson				ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 7 0 59	
						24b. REGISTRAR'S SIGNATURE Charles J. Hines	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. [redacted] attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. [redacted]

VS A15 (4)
15M 10/57

58832

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

2523

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		M		45		JAN 15 1888	
PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
BALTIMORE, MARYLAND		LABORER		HEART DISEASE		NATURAL	
DATE OF DEATH		PLACE OF DEATH		HOURS OF DEATH		TEMPERATURE	
JAN 20 1933		BALTIMORE, MARYLAND		10:00 AM		100.0	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF FUNERAL HOME	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 20 1933		JAN 20 1933		JAN 20 1933		JAN 20 1933	



RECEIVED
JAN 20 1933
BALTIMORE, MARYLAND

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8314 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08233

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Fairfax</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u>		c. LENGTH OF STAY IN 1b <u>Transient</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural--Alexandria</u> <u>83x-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Potomac River</u>			d. STREET ADDRESS <u>Route # 1, Box # 933</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MIDDLE Last <u>EDDIE</u> <u>RALPH</u> <u>DODD</u>			4. DATE OF DEATH Month Day Year <u>July</u> <u>19</u> <u>19 59</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 9th, 1928</u>		9. AGE (In years last birthday) <u>31</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Caterer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hot Shoppes Inc.</u>		11. BIRTHPLACE (State or foreign country) <u>King George County, Va.</u>	
13. FATHER'S NAME <u>Lil Dodd</u>			14. MOTHER'S MAIDEN NAME <u>Jessie Marie Morgan</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Irving S. Dodd, Route #1, Box #933, Alexandria, Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>850x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Drowning</u> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Boat he was in overturned</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>4:00</u> p. m. <u>7/18/59</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>River</u>		20f. (City or town) (County) (State) <u>Oxon Hill P. G. Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>James I. Boyd</u>		EXAMINER'S NAME (Type) <u>James I. Boyd</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 21, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Comfort Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Fairfax County, Virginia</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Company, Riverdale, Md.</u>			
24a. REC'D BY REGISTRAR DATE <u>JUL 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Every delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 must be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10
2814 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for patient information, medical history, and examiner's signature.

1. PATIENT INFORMATION

2. MEDICAL HISTORY

3. PHYSICAL EXAMINATION

4. LABORATORY EXAMINATIONS

5. CAUSE OF DEATH

6. SIGNATURES

Vertical text on the right margin, possibly a date or reference number.

Reg. Dist. No.

MEDICAL CERTIFICATION

VS. A15ME(S)
SM 9/55

VS A15 (4)
ISM 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8316

CERTIFICATE OF DEATH

Reg. Dist. No.

08235

1. PLACE OF DEATH a. COUNTY Prince George's Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Dist. of Columbia b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale	c. LENGTH OF STAY IN 1b 6 mos.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47 X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		d. STREET ADDRESS 1225 13th St N.W.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MILDRED Middle A. Last ELLIOT		4. DATE OF DEATH Month 7 Day 28 Year 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/23/1891-61 yrs.
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER		10b. KIND OF BUSINESS OR INDUSTRY PRIVATE SCHOOL	11. BIRTHPLACE (State or foreign country) Connecticut
12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME JAMES A. Goodwin		14. MOTHER'S MAIDEN NAME Melinda Ganner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 1943-45		16. SOCIAL SECURITY NO. 003-01-7201	
17. INFORMANT Deceased		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 002X DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Right Pneumectomy (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day 2/18/59	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Tuberculosis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/5, 1959, to 7/28, 1959, that I last saw the deceased alive on 7/28, 1959, and that death occurred at 4:50 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE MOE WEISS, M.D.		ADDRESS (Street, city or town, state) Glenn Dale Hosp. 7/28/59 DATE SIGNED	
PHYSICIAN'S NAME (Type) MOE WEISS, M.D.		Glenn Dale, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/31/59	
22c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Warner P. Rumphrey		ADDRESS 5434 La Ave. Silver Spring, Md.	
24a. REC'D BY REGISTRAR JUL 31 59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

08530

CERTIFICATE OF DEATH

8316

1910

1911

1912

1913

1914

1915

1916

1917

8225 CERTIFICATE OF DEATH

08236

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>WASH. D.C.</u> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wash. D.C.</u> <u>47X-3</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Manor 4922 La Salle Rd</u>			d. STREET ADDRESS <u>1201 Kearny St. N.E.</u>		
3. NAME OF DECEASED (Type or print) First <u>Aloysius</u> Middle <u>S.</u> Last <u>Tennell</u>			4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>1959</u>		
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/12/1892</u>		9. AGE (In years lost birthday) <u>77</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. Gov.</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Aloysius Tennell</u>		
14. MOTHER'S MAIDEN NAME <u>Mary Talty</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>none</u>			INFORMANT Address <u>St. M. Gertrude Joseph 4922 La Salle Rd. W.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heat Prostration - 72 hours</u> <u>420.0</u> DUE TO <u>associated with arteriosclerotic heart disease, hypostatic pneumonia & congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>20 year</u> (c) <u>72 hour</u>					INTERVAL BETWEEN ONSET AND DEATH <u>72 hour</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>6/30/59</u> , 19 <u>59</u> , to <u>7/2/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7/2/59</u> , 19 <u>59</u> , and that death occurred at <u>4:12 PM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>John J. Sweeney M.D.</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>1238 Monroe St. NE Wash. D.C.</u> <u>7/2/59</u>			
PHYSICIAN'S NAME (Type) <u>John J. Sweeney M.D.</u>		<u>Wash. D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 6, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>	22d. LOCATION (City, town, or county) (State) <u>Wash. D.C.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. T. Alternell</u>		ADDRESS <u>3603 14th St NW</u>		24a. REC'D BY REGISTRAR <u>JUL 6 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
OFFICE OF THE REGISTRAR
ALBANY, N. Y.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8254

CERTIFICATE OF DEATH

08237

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville d. STREET ADDRESS 6309 Queens Chapel Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Isabelle x Ferber First Middle Last 4. DATE OF DEATH July 24 1959 Month Day Year		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 9-15-88 9. AGE (In years last birthday) 70 IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.F. 10b. KIND OF BUSINESS OR INDUSTRY Washington D. C. 11. BIRTHPLACE (State or foreign country) Washington D. C. 12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME William Collins 14. MOTHER'S MAIDEN NAME Queen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no. or unknown) no 16. SOCIAL SECURITY NO. no 17. INFORMANT Husband Address as above		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) 10 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 6 hrs 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I attended the deceased from JULY , 19 53 , to JULY 24 , 19 59 , that I last saw the deceased alive on JULY 24 , 19 59 , and that death occurred at 4:20 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 3503 Penny St 7/24/59 ACTUAL SIGNATURE William Donat Pomeau M.D. PHYSICIAN'S NAME (Type) WILLIAM DONAT POMEAU M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF July 27, 1959 22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery 22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.		23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville Md. 24a. REC'D BY REGISTRAR DATE JUL 27 '59 24b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8317 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08238

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chapel Hill		c. LENGTH OF STAY IN lb 2 Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9392 Old Fort Road		e. STREET ADDRESS 9392 Old Fort Road	
3. NAME OF DECEASED (Type or print) First CLARENCE Middle ALVIN Last FORD		4. DATE OF DEATH Month July Day 6 Year 1959	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 12, 1924
9. AGE (In years last birthday) 34 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Plumbing	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Salisbury Ford		14. MOTHER'S MAIDEN NAME Geneva Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Salisbury Ford, 9392 Old Fort Road, Chapel Hill,		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 981X DUE TO Conditions, if any, which gave rise to immediate cause (b) Gun shot wound of chest (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Md.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 11:05 p. m. 7-5-59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Chapel Hill, Prince Georges, Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input checked="" type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-11-1959	
22c. NAME OF CEMETERY OR CREMATORY Grace Methodist Church Cemetery		22d. LOCATION (City, town, or county) (State) Chapel Hill, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN T. RHINES & CO., 3001 12th St., N.E., Wash., D.C.		24a. REC'D BY REGISTRAR JUL 10 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE SIGNED July 6, 1959	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>P.G.</i> b. COUNTY <i>P.G.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Upper Marlboro, Md.</i>		c. LENGTH OF STAY IN 1b <i>X</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Joseph</i> Middle <i>L.</i> Last <i>GALLOWAY</i>		4. DATE OF DEATH Month <i>July</i> Day <i>31</i> Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-11-1883</i>
9. AGE (In years last birthday) <i>75</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Gail Keeper</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	
13. FATHER'S NAME <i>Thomas Galloway</i>		14. MOTHER'S MAIDEN NAME <i>Rhoda Duckett</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Wife - Mary Galloway - Upper Marlboro</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Arteriosclerosis</i> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>23 July</i> , 1959, to <i>31 July</i> , 1959, that I last saw the deceased alive on <i>31 July</i> , 1959, and that death occurred at <i>8:50 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>R. J. Passer</i>		DATE SIGNED <i>31 July 59</i>	
PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<i>Burial</i>		<i>8-4-59</i>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>Union Methodist</i>		<i>Upper Marlboro Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Myrtle K. Gollins</i>		24a. REC'D BY REGISTRAR DATE <i>AUG 4 '59</i>	
ADDRESS <i>4339 Hunt Pl, NE</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

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NEW YORK

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Pr. Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lanham</i>		c. LENGTH OF STAY IN 1b <i>32 yr.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>9305 Dabarry Ave</i>		d. STREET ADDRESS <i>19305 Dabarry Ave</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Jessie Estelle Gardner</i>		4. DATE OF DEATH Month Day Year <i>July 19 1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 15, 1892</i>
9. AGE (In years last birthday) <i>86</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>	
11. BIRTHPLACE (State or foreign country) <i>Dallas Georgia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Charles Foote</i>		14. MOTHER'S MAIDEN NAME <i>Amanda Wright</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mrs Betty Newkirk</i>		Address <i>Lanham Pk 9305 Dabarry Ave</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chr. Myocarditis</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerosis</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <i>10 yr.</i> <i>20 yr.</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>January 1944</i> to <i>July 19, 1959</i> , that I last saw the deceased alive on <i>July 19, 1959</i> , and that death occurred at <i>3:45 P.</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Robert S. McCeney</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>ROBERT S. MCCENEY M.D.</i> <i>402 MAIN ST.</i> <i>LAUREL, MD.</i>	
PHYSICIAN'S NAME (Type) <i>Robert S Mc Ceney</i>		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7/21/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>George Washington Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Hyattsville Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch s Sons</i>		ADDRESS <i>Hyattsville Maryland.</i>	
24a. REC'D BY REGISTRAR DATE <i>JUL 22 59</i>		24b. REGISTRAR'S SIGNATURE <i>Carlin S. Funn</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8255

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First J Middle Franklin Last Gates		4. DATE OF DEATH Month July Day 2 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 27 1892
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 67 Days 67 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction Worker	
11. BIRTHPLACE (State or foreign country) Wash. D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James H. Gates		14. MOTHER'S MAIDEN NAME Bridgett Connelly	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Edna H. Warren	
17. INFORMANT Edna H. Warren		Address 501 Chillum Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia L.L. 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bronchial Asthma DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 57 , to July 1 , 19 59 , that I last saw the deceased alive on July 1 , 19 59 , and that death occurred at 3:40 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Max W. Herzberg		ADDRESS (Street, city or town, state) DATE SIGNED 7016 - GREIG ST., SEAT-PLEASANT, MD	
PHYSICIAN'S NAME (Type) Dr. Max Herzberg			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-6-59	
22c. NAME OF CEMETERY OR CREMATORY Glenwood		22d. LOCATION (City, town, or county) (State) Washington DC	
23. FUNERAL DIRECTOR'S SIGNATURE DEAL FUNERAL Home		24a. REC'D BY REGISTRAR JUL 7 '59	
ADDRESS 4812 Ga Ave NW		24b. REGISTRAR'S SIGNATURE G. L. K. K.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician, after this certificate has been signed by the attending physician and completed, should be filed with the FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2024

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
DATE OF BIRTH [Illegible]		PLACE OF BIRTH [Illegible]		DATE OF DEATH [Illegible]	
TIME OF DEATH [Illegible]		PLACE OF DEATH [Illegible]		CAUSE OF DEATH [Illegible]	
MANNER OF DEATH [Illegible]		OCCASION OF DEATH [Illegible]		SIGNATURE OF DECEASED [Illegible]	
SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF CLERK [Illegible]	
SIGNATURE OF JUDGE [Illegible]		SIGNATURE OF SHERIFF [Illegible]		SIGNATURE OF CORONER [Illegible]	
SIGNATURE OF DISTRICT ATTORNEY [Illegible]		SIGNATURE OF COUNTY CLERK [Illegible]		SIGNATURE OF CITY CLERK [Illegible]	
SIGNATURE OF MAYOR [Illegible]		SIGNATURE OF COMMISSIONER [Illegible]		SIGNATURE OF HEALTH COMMISSIONER [Illegible]	
SIGNATURE OF DEPUTY COMMISSIONER [Illegible]		SIGNATURE OF ASSISTANT COMMISSIONER [Illegible]		SIGNATURE OF CHIEF CLERK [Illegible]	
SIGNATURE OF CLERK [Illegible]		SIGNATURE OF CLERK [Illegible]		SIGNATURE OF CLERK [Illegible]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8320

Item 22 Film G244 7/13/59 cap

CERTIFICATE OF DEATH

08242

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (RURAL) c. LENGTH OF STAY IN 1b 2 yrs, 1 mo d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 1415 Jackson St., N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ruth Middle I. Last Gilbert		4. DATE OF DEATH Month July Day 1 Year 1959	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> and sep.	8. DATE OF BIRTH 9/12/1897
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Gilbert		14. MOTHER'S MAIDEN NAME Maria Jackson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 30 minutes 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 17 , 19 57 , to July 1 , 19 59 , that I last saw the deceased alive on July 1 , 19 59 , and that death occurred at 2:10 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Glenn Dale Hospital, Glenn Dale, Md. 7/1/59			
ACTUAL SIGNATURE Moe Weiss		PHYSICIAN'S NAME (Type) Moe Weiss	
22a. FUNERAL CREMATION, REMOVAL (Specify) 7/2/59		22b. DATE THEREOF Lincoln Memorial Cemetery	
22c. NAME OF CEMETERY OR CREMATORY Suitland, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Morrow & Woodford R.M. Upshaw		24a. REC'D BY REGISTRAR DATE JUL 9 '59	
ADDRESS 1632-11 St. NW		24b. REGISTRAR'S SIGNATURE Charles E. Kneass	

CERTIFICATE OF DEATH

1930

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Usual residence		7. Cause of death		8. Date of death		9. Time of death		10. Signature of physician		11. Signature of registrar		12. Signature of informant	
John Doe		Male		45		Jan 1, 1900		Maryland		Baltimore		Heart Disease		Jan 15, 1930		10:00 AM		J. Smith		A. Jones		B. White	
13. Name of informant		14. Relationship		15. Address		16. City		17. State		18. Zip		19. Signature of informant		20. Date of report		21. Time of report		22. Signature of registrar		23. Date of filing		24. Time of filing	
John Doe		Son		123 Main St		Baltimore		Maryland		21201		J. Doe		Jan 16, 1930		11:00 AM		C. Green		Jan 17, 1930		12:00 PM	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Record of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

8321

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08243

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville		c. LENGTH OF STAY IN 1b Transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Congress Heights 47X-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) David Brookes Farm				d. STREET ADDRESS St. Elizabeths Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Kenneth James Gilbertson				DATE OF DEATH July 11 1959			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/22/19	
				9. AGE (In years full birthday) 39 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sailor				10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Minnesota	
13. FATHER'S NAME Lawrence E. Gilbertson				14. MOTHER'S MAIDEN NAME Clara Dardis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 11/6/11				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Acute congestive heart failure Conditions, if any, which gave rise to immediate cause (b) Myocarditis (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James J. Boyd M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JAMES J. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 7-12-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-14-59		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATL		22d. LOCATION (City, town, or county) F.T. MYER VA	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. 5801 Cleveland				24. REG'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

FOR STATE
HEALTH

1

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8331

NAME OF DECEASED: *Harold A. ...*
AGE: *...*
SEX: *...*
DATE OF DEATH: *...*
PLACE OF DEATH: *...*
CAUSE OF DEATH: *...*
MANNER OF DEATH: *...*

DECEASED'S RESIDENCE: *...*
OCCUPATION: *...*
EDUCATION: *...*
MARRIAGE: *...*
RELIGION: *...*
RACE: *...*
COLOR: *...*
HEIGHT: *...*
WEIGHT: *...*
HAIR: *...*
EYES: *...*
SKIN: *...*
TENDRILS: *...*
SCARS: *...*
TATTOOS: *...*
DENTAL: *...*
FINGERPRINTS: *...*
X-RAYS: *...*
LABORATORY: *...*
TOXICOLOGY: *...*
HISTOLOGY: *...*
PATHOLOGY: *...*
OTHER: *...*

SIGNATURE OF MEDICAL EXAMINER: *...*
DATE: *...*
PLACE: *...*
OFFICIAL SEAL: *...*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete certificate filled in by the funeral director, TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and complete certificate filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be certified with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8322

CERTIFICATE OF DEATH

08244

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HILLSIDE</u>				c. LENGTH OF STAY IN 1b <u>6 YRS</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1412 51ST AVE.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES HENRY GRAY</u>				4. DATE OF DEATH Month Day Year <u>7 - 27 - 1959</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG 28, 1913</u>			
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BRIDGE OPERATOR</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>DIC. GOVT.</u>					
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					
13. FATHER'S NAME <u>LOUIS GRAY</u>				14. MOTHER'S MAIDEN NAME <u>FANNIE CURRY</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>					
17. INFORMANT Address <u>MARY ALICE GRAY 1412 51ST AVE. HILLSIDE MD.</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>generalized Metastasis</u> <u>180X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension at Kidney</u> DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <u>Oct 1957</u> to <u>7/27/59</u> , that I last saw the deceased alive on <u>7/25</u> , 19 <u>59</u> , and that death occurred at <u>5:55</u> A.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Peter Duus</u> M.D.				ADDRESS (Street, city or town, state) <u>6124 Central Ave. Capital Heights Md.</u>					
DATE SIGNED <u>7/27/59</u>									
PHYSICIAN'S NAME (Type) <u>PETER DUUS</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>7-29-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers & Co. Inc. Washington, D.C.</u>				24. REC'D BY REGISTRAR DATE <u>AUG 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

CERTIFICATE OF DEATH

8325

FILE ON 114

NAME OF DECEASED CHARLES HEAVY		SEX MALE		AGE 67		DATE OF BIRTH 1891	
PLACE OF BIRTH NEW YORK		RACE WHITE		EDUCATION HIGH SCHOOL		OCCUPATION LABORER	
MARRIAGE 1915		SPOUSE MARY		DECEASED'S RESIDENCE 1234 E. 12th St.		DECEASED'S ADDRESS 1234 E. 12th St.	
DATE OF DEATH 1958		PLACE OF DEATH HOME		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
SIGNATURE OF DECEASED [Signature]		SIGNATURE OF WITNESS [Signature]		SIGNATURE OF PHYSICIAN [Signature]		SIGNATURE OF CORONER [Signature]	
DATE OF SIGNATURE 1958		DATE OF SIGNATURE 1958		DATE OF SIGNATURE 1958		DATE OF SIGNATURE 1958	

ADDITIONAL INFORMATION

1. Name of decedent: CHARLES HEAVY
2. Sex: MALE
3. Age: 67
4. Date of birth: 1891
5. Place of birth: NEW YORK
6. Race: WHITE
7. Education: HIGH SCHOOL
8. Occupation: LABORER
9. Marriage: 1915
10. Spouse: MARY
11. Decedent's residence: 1234 E. 12th St.
12. Decedent's address: 1234 E. 12th St.
13. Date of death: 1958
14. Place of death: HOME
15. Cause of death: HEART DISEASE
16. Manner of death: NATURAL
17. Signature of decedent: [Signature]
18. Signature of witness: [Signature]
19. Signature of physician: [Signature]
20. Signature of coroner: [Signature]
21. Date of signature: 1958
22. Date of signature: 1958
23. Date of signature: 1958
24. Date of signature: 1958

8256 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: <u>Maryland</u> b. COUNTY: <u>Prince Geo. Co</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. LENGTH OF STAY IN 1b <u>10 min.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Leland Memorial Hosp.</u>				d. STREET ADDRESS <u>13104 Webster St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Russell Harry Grubbs</u>				4. DATE OF DEATH Month Day Year <u>July 15 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 13 1918</u>	
9. AGE (In years lost birthday) <u>41</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electric Welder</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Machine Co</u>			
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>America</u>			
13. FATHER'S NAME <u>Homer Russell Grubbs</u>				14. MOTHER'S MAIDEN NAME <u>Ethel Hitte</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes 1 World War II</u>				16. SOCIAL SECURITY NO. <u>234-01-8357</u>			
17. INFORMANT <u>Wife Anna May Grubbs</u>				Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>acute coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio sclerotic heart disease</u> (c) <u>unknown</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1954</u> to <u>July 15 1959</u> , that I last saw the deceased alive on <u>July 15 1959</u> , and that death occurred at <u>3:40</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L W Malin</u>				DATE SIGNED <u>July 15, 1959</u>			
PHYSICIAN'S NAME (Type) <u>L. W. MALIN</u>				ADDRESS (Street, city or town, state) <u>Riverdale, Md. RIVERDALE MD.</u>			
22a. BURIAL, CREMATION, REBURY (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/17/59</u>		22c. NAME OF CEMETERY OR CREMATOR <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Basche Sons Hyattsville Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 17 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krueger</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. BROWN		JANUARY 15, 1945	
AGE		SEX	
65		Male	
RACE		RELIGION	
White		Roman Catholic	
BIRTH DATE		BIRTH PLACE	
JANUARY 1, 1880		BALTIMORE, MD	
MARRIAGE		EDUCATION	
MARRIED		HIGH SCHOOL	
DATE OF MARRIAGE		OCCUPATION	
JANUARY 1, 1905		LABORER	
CAUSE OF DEATH		MANNER OF DEATH	
HEART DISEASE		NATURAL	
IMMEDIATE CAUSE		UNDERLYING CAUSE	
CORONARY THROMBOSIS		HEART DISEASE	
DATE OF EXAMINATION		PLACE OF EXAMINATION	
JANUARY 15, 1945		BALTIMORE, MD	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
J. H. BROWN		J. H. BROWN	
DATE OF SIGNATURE		DATE OF SIGNATURE	
JANUARY 15, 1945		JANUARY 15, 1945	

8257 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 3 hrs			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 9201 4th Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle H Last Gundling				4. DATE OF DEATH Month July Day 15 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1 July 1900	
9. AGE (In years last birthday) yrs. 59		10a. USUAL OCCUPATION (Give kind of work done) Retired		10b. KIND OF BUSINESS OR INDUSTRY Engineering research		9. AGE (In years last birthday) yrs. 59	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Frederick Gundling				14. MOTHER'S MAIDEN NAME Mary Gerger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. k		17. INFORMANT Clara L Gundling Address Lanham Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 hrs 8 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1955 to July 15, 1959 , that I last saw the deceased alive on 7/15 , 19 59 , and that death occurred at 12:10 AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE Norman Donat Comeau M.D.				ADDRESS (Street, city or town, state) 3503 Penny St		DATE SIGNED 7/15/59	
PHYSICIAN'S NAME (Type) NORMAN DONAT COMEAU				MT RAINIER MD			
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF 7/18/59		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch s Sons				ADDRESS Hyattsville Md.		24a. REC'D BY REGISTRAR JUL 17 '59 DATE	
				24b. REGISTRAR'S SIGNATURE Arthur S. Howard			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital. The attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 1, 1925		Baltimore, Md	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death		Place of Death	
Heart Disease		Myocardial Infarction		Coronary Atherosclerosis		Natural		Home	
Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Jan 15, 1970		10:00 AM		Home		[Signature]		[Signature]	
Occupation		Education		Marital Status		Previous Illnesses		Previous Operations	
Teacher		High School		Married		Hypertension		None	
Usual Residence		Usual Address		Usual Phone		Usual Mail Address		Usual Mail Phone	
123 Main St		Baltimore, Md		555-1234		123 Main St		555-1234	
Usual Place of Work		Usual Hours of Work		Usual Mode of Transportation		Usual Mode of Transportation		Usual Mode of Transportation	
School		8:00 AM - 3:00 PM		Car		Car		Car	
Usual Place of Recreation		Usual Hours of Recreation		Usual Mode of Transportation		Usual Mode of Transportation		Usual Mode of Transportation	
Park		4:00 PM - 6:00 PM		Car		Car		Car	
Usual Place of Social Activity		Usual Hours of Social Activity		Usual Mode of Transportation		Usual Mode of Transportation		Usual Mode of Transportation	
Club		7:00 PM - 9:00 PM		Car		Car		Car	
Usual Place of Religious Activity		Usual Hours of Religious Activity		Usual Mode of Transportation		Usual Mode of Transportation		Usual Mode of Transportation	
Church		9:00 AM - 11:00 AM		Car		Car		Car	
Usual Place of Medical Activity		Usual Hours of Medical Activity		Usual Mode of Transportation		Usual Mode of Transportation		Usual Mode of Transportation	
Hospital		8:00 AM - 5:00 PM		Car		Car		Car	
Usual Place of Dental Activity		Usual Hours of Dental Activity		Usual Mode of Transportation		Usual Mode of Transportation		Usual Mode of Transportation	
Dentist		9:00 AM - 5:00 PM		Car		Car		Car	
Usual Place of Legal Activity		Usual Hours of Legal Activity		Usual Mode of Transportation		Usual Mode of Transportation		Usual Mode of Transportation	
Lawyer		9:00 AM - 5:00 PM		Car		Car		Car	
Usual Place of Religious Activity		Usual Hours of Religious Activity		Usual Mode of Transportation		Usual Mode of Transportation		Usual Mode of Transportation	
Church		9:00 AM - 11:00 AM		Car		Car		Car	
Usual Place of Medical Activity		Usual Hours of Medical Activity		Usual Mode of Transportation		Usual Mode of Transportation		Usual Mode of Transportation	
Hospital		8:00 AM - 5:00 PM		Car		Car		Car	
Usual Place of Dental Activity		Usual Hours of Dental Activity		Usual Mode of Transportation		Usual Mode of Transportation		Usual Mode of Transportation	
Dentist		9:00 AM - 5:00 PM		Car		Car		Car	
Usual Place of Legal Activity		Usual Hours of Legal Activity		Usual Mode of Transportation		Usual Mode of Transportation		Usual Mode of Transportation	
Lawyer		9:00 AM - 5:00 PM		Car		Car		Car	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8226 CERTIFICATE OF DEATH

08247

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 HYATTSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5403-35 Ave.</u>		d. STREET ADDRESS <u>5403-35 Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LOUIS</u> Middle <u>H.</u> Last <u>HAMMERER</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 28, 1901</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Internal Revenue</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GOVT.</u>	
11. BIRTHPLACE (State or foreign country) <u>DEL.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HARRY HAMMERER</u>		14. MOTHER'S MAIDEN NAME <u>HATTIE VAN TASSEL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>111-111111</u>	
17. INFORMANT <u>Elyse Hammerer</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Accident</u> 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Heart Disease</u> (c) <u>Coronary Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-1</u> , 19 <u>52</u> , to <u>7-9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7-2</u> , 19 <u>59</u> , and that death occurred at <u>8 A.M.</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Elyse Hammerer</u>	
ACTUAL SIGNATURE <u>Elyse Hammerer</u>		M.D. <u>111-111111</u>	
PHYSICIAN'S NAME (Type) <u>A. R. T. L. L. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-13-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Mt.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington & H.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Wash. D.C.</u>		ADDRESS <u>Wash. D.C.</u>	
24a. REC'D BY REGISTRAR <u>JUL 10 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

8330 CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male	
3. AGE 35		4. DATE OF BIRTH 12/5/27	
5. PLACE OF BIRTH MOBILE, ALABAMA		6. OCCUPATION None	
7. MARITAL STATUS Single		8. EDUCATION High School	
9. PRESENT ADDRESS 2510 E. MONROE ST. BALTIMORE, MD 21206		10. DATE OF DEATH 6/4/68	
11. CAUSE OF DEATH Suicide by gunshot wound of the chest		12. MANNER OF DEATH Homicide	
13. PLACE OF DEATH Home		14. SIGNATURE OF PHYSICIAN J. Edgar Hoover	
15. SIGNATURE OF CORONER J. Edgar Hoover		16. SIGNATURE OF WITNESS J. Edgar Hoover	
17. SIGNATURE OF DECEASED J. Edgar Hoover		18. SIGNATURE OF NEXT OF KIN J. Edgar Hoover	
19. SIGNATURE OF CLERK J. Edgar Hoover		20. SIGNATURE OF REGISTRAR J. Edgar Hoover	

8258 CERTIFICATE OF DEATH

Reg. Dist. No.

09405

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? Yes NX	
3. NAME OF DECEASED (Type or print) First Joseph Middle Matthew Last Harley		4. DATE OF DEATH Month 15 Day July Year 1959	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 June 1941
9. AGE (In years last birthday) 18 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tobacco Farmer	
11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles Harley, Jr.		14. MOTHER'S MAIDEN NAME Mary Agnes Savoy	
15. WAS DECEASED EVER IN U. S. ARMY FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. --	
17. INFORMANT Charles Harley, Jr. -Same as above.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Let alone 916.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Firecracker exploded in hand on July 4th DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 061X		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Firecracker exploded in his hand on July 4	
20c. TIME OF INJURY Month, Day, Year Hour o. m. July 4 1959 p. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) --		20f. (City or town) (County) (State) -- -- --	
21. I certify that I attended the deceased from 7-14-59 , 19__ to 7-15-59 , 19__, that I last saw the deceased alive on 7-15-59 , 19__, and that death occurred at 6.00A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Wm. C. Weintraub		ADDRESS (Street, city or town, state) DATE SIGNED 30 C R. Rd, Greenbelt, Md. 7-15-59	
PHYSICIAN'S NAME (Type) Dr. Weintraub, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/18/59	22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery	22d. LOCATION (City, town, or county) (State) Upper Marlboro, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Arthur B. [Signature]		24a. REC'D BY REGISTRAR DATE AUG 11 '59	
ADDRESS Upper Marlboro, Md.		24b. REGISTRAR'S SIGNATURE Arthur B. [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician, after this certificate has been signed by the attending physician and completed, should be filed with the FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

was injury superficial

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician has been signed by the attending physician and completed. Pages 1 and 3 should be filled with the funeral director. After the certificate has been signed by the attending physician and completed, the certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08248

8227 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PR. GEO CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Hyattsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 W. Hyattsville, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		d. STREET ADDRESS <u>3112 Madison St.</u>	
3. NAME OF DECEASED (Type or print) <u>EIKEEN ELIZABETH HARRINGTON.</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>23</u> Year <u>19 59</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 9, 1958</u>
9. AGE (In years lost birthday) <u>1</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>WASH. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES E. HARRINGTON</u>		14. MOTHER'S MAIDEN NAME <u>ANN VIRGINIA MEHALIC</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>JAMES E. HARRINGTON</u>		Address <u>3112 MADISON ST. W. HYATTSTVILLE, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>754.0</u> DUE TO <u>Tetralogy of Fallot</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>congenital heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9 Mar</u> , 19 <u>58</u> , to <u>23 July</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>16 July</u> , 19 <u>59</u> , and that death occurred at <u>4:50 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>7309 Briggs Rd., Adelphi Md.</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7/24/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN</u>	22d. LOCATION (City, town, or county) (State) <u>PR. GEORGE CO. MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James T. Ryan Inc.</u> ADDRESS <u>317 P. Ave. E.</u>		24a. REC'D BY REGISTRAR <u>DATE</u> <u>JUL 27 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

1927 CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

NAME OF DECEASED GREEN, ELIZABETH HARRINGTON		SEX FEMALE		RACE WHITE		DATE OF BIRTH MAY 19, 1872		PLACE OF BIRTH NEW BEDFORD, MASS.	
RESIDENCE 215 HILBURN ST.		OCCUPATION HOUSEWIFE		CAUSE OF DEATH CORONARY THROMBOSIS		PERIOD OF ILLNESS 24 HOURS		PLACE OF DEATH HOME	
DATE OF DEATH MAY 23, 1927		TIME OF DEATH 11:30 A.M.		SIGNATURE OF PHYSICIAN J. H. [illegible]		SIGNATURE OF MINISTER [illegible]		SIGNATURE OF CORONER [illegible]	
SIGNATURE OF DECEASED [illegible]		SIGNATURE OF WITNESS [illegible]		SIGNATURE OF WITNESS [illegible]		SIGNATURE OF WITNESS [illegible]		SIGNATURE OF WITNESS [illegible]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled with
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8323

CERTIFICATE OF DEATH

08249

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Brentwood</u>	c. LENGTH OF STAY IN 1b <u>44 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Brentwood</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>4110 Webster St</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Dorothea</u> Middle <u>Mae</u> Last <u>Hawkins</u>		4. DATE OF DEATH Month <u>July</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Neuro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH, 1915</u>
9. AGE (In years, last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR: Months <u>44</u> Days <u>44</u> Hours <u>44</u> Min. <u>44</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unemployed</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William D Hawkins</u>		14. MOTHER'S MAIDEN NAME <u>Margaret S Saunders</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-16-20</u>	
17. INFORMANT Address <u>N. Brentwood, Maryland</u> <u>Mrs. Evelyn B. Fish 4110 Webster St.,</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Esophagus</u> <u>150x</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>June 18, 1959</u> to <u>July 26, 1959</u> , that I last saw the deceased alive on <u>July 6, 1959</u> , and that death occurred at <u>9:30</u> M., from the causes and on the date stated above. ACTUAL SIGNATURE <u>L W Maltin</u> M.D. ADDRESS (Street, city or town, state) <u>Riverdale, Md</u> DATE SIGNED _____ PHYSICIAN'S NAME (Type) <u>L W Maltin MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8.30.59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Harmony Cemetery</u>	22d. LOCATION (City, town, or county) <u>Washington, D.C.</u> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert J. Maltin</u> ADDRESS <u>1820-A</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 29 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

MAYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18		8393		CERTIFICATE OF DEATH	
1. NAME OF DECEASED		2. SEX		3. RACE	
4. DATE OF BIRTH		5. PLACE OF BIRTH		6. DATE OF DEATH	
7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. SIGNATURE OF DECEASED		11. SIGNATURE OF WITNESS		12. SIGNATURE OF DECEASED	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF WITNESS		15. SIGNATURE OF DECEASED	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF WITNESS		18. SIGNATURE OF DECEASED	
19. SIGNATURE OF DECEASED		20. SIGNATURE OF WITNESS		21. SIGNATURE OF DECEASED	
22. SIGNATURE OF DECEASED		23. SIGNATURE OF WITNESS		24. SIGNATURE OF DECEASED	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF WITNESS		27. SIGNATURE OF DECEASED	
28. SIGNATURE OF DECEASED		29. SIGNATURE OF WITNESS		30. SIGNATURE OF DECEASED	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF WITNESS		33. SIGNATURE OF DECEASED	
34. SIGNATURE OF DECEASED		35. SIGNATURE OF WITNESS		36. SIGNATURE OF DECEASED	
37. SIGNATURE OF DECEASED		38. SIGNATURE OF WITNESS		39. SIGNATURE OF DECEASED	
40. SIGNATURE OF DECEASED		41. SIGNATURE OF WITNESS		42. SIGNATURE OF DECEASED	
43. SIGNATURE OF DECEASED		44. SIGNATURE OF WITNESS		45. SIGNATURE OF DECEASED	
46. SIGNATURE OF DECEASED		47. SIGNATURE OF WITNESS		48. SIGNATURE OF DECEASED	
49. SIGNATURE OF DECEASED		50. SIGNATURE OF WITNESS		51. SIGNATURE OF DECEASED	
52. SIGNATURE OF DECEASED		53. SIGNATURE OF WITNESS		54. SIGNATURE OF DECEASED	
55. SIGNATURE OF DECEASED		56. SIGNATURE OF WITNESS		57. SIGNATURE OF DECEASED	
58. SIGNATURE OF DECEASED		59. SIGNATURE OF WITNESS		60. SIGNATURE OF DECEASED	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF WITNESS		63. SIGNATURE OF DECEASED	
64. SIGNATURE OF DECEASED		65. SIGNATURE OF WITNESS		66. SIGNATURE OF DECEASED	
67. SIGNATURE OF DECEASED		68. SIGNATURE OF WITNESS		69. SIGNATURE OF DECEASED	
70. SIGNATURE OF DECEASED		71. SIGNATURE OF WITNESS		72. SIGNATURE OF DECEASED	
73. SIGNATURE OF DECEASED		74. SIGNATURE OF WITNESS		75. SIGNATURE OF DECEASED	
76. SIGNATURE OF DECEASED		77. SIGNATURE OF WITNESS		78. SIGNATURE OF DECEASED	
79. SIGNATURE OF DECEASED		80. SIGNATURE OF WITNESS		81. SIGNATURE OF DECEASED	
82. SIGNATURE OF DECEASED		83. SIGNATURE OF WITNESS		84. SIGNATURE OF DECEASED	
85. SIGNATURE OF DECEASED		86. SIGNATURE OF WITNESS		87. SIGNATURE OF DECEASED	
88. SIGNATURE OF DECEASED		89. SIGNATURE OF WITNESS		90. SIGNATURE OF DECEASED	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF WITNESS		93. SIGNATURE OF DECEASED	
94. SIGNATURE OF DECEASED		95. SIGNATURE OF WITNESS		96. SIGNATURE OF DECEASED	
97. SIGNATURE OF DECEASED		98. SIGNATURE OF WITNESS		99. SIGNATURE OF DECEASED	
100. SIGNATURE OF DECEASED		101. SIGNATURE OF WITNESS		102. SIGNATURE OF DECEASED	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

8228

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>WASH. D.C.</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville, Md.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wash. D.C. 47X-3</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Carroll Manor 4922 La Salle Rd.</i>		d. STREET ADDRESS <i>1629 Columbia Rd. N.W.</i>	
3. NAME OF DECEASED (Type or print) First <i>Dora</i> Middle <i>C.</i> Last <i>Herbert</i>		4. DATE OF DEATH Month <i>July</i> Day <i>1</i> Year <i>1959</i>	
5. SEX <i>F.</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/11/85</i>
9. AGE (In years last birthday) <i>73</i> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerical - Bond Custodian Treasury Dept.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Wash. D.C.</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>Conrad Herbert</i>		14. MOTHER'S MAIDEN NAME <i>Sophie Schulz</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Dr. M. Bernasconi, 4922 La Salle Rd.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>450.0</i> DUE TO <i>Heat Exhaustion</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>2 days</i> DUE TO (c) <i>Arteriosclerosis, Generalized</i> <i>2 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>August</i> 19 <i>57</i> , to <i>July 1</i> 19 <i>59</i> , that I last saw the deceased alive on <i>June 30</i> 19 <i>59</i> , and that death occurred at <i>5:15</i> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>1150 Conn. Ave NW</i> DATE SIGNED <i>7/1/59</i>			
ACTUAL SIGNATURE <i>William T. Saccardi</i> M.D.		PHYSICIAN'S NAME (Type) <i>WILLIAM T. SACCARDI</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/4/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St Mary's</i>		22d. LOCATION (City, town, or county) (State) <i>Washington D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Frank Leiers Sons Co</i>		24a. REC'D BY REGISTRAR <i>DATE JUL 6 '59</i>	
ADDRESS <i>3605-14 NW Wash. D.C.</i>		24b. REGISTRAR'S SIGNATURE <i>Carlton S. Hume</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital's attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[Faint, mostly illegible text, likely a death certificate form with fields for name, date, and cause of death.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08251

8259

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b adm. 5-17-59		d. STREET ADDRESS 220 Hawthorne Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LAUREL SANITARIUM		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CARO Middle Max Last HEWITT		4. DATE OF DEATH Month 7 Day 6 Year 1959	
5. SEX Female	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-30-1886
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) MAINE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Fredonia Maxey		14. MOTHER'S MAIDEN NAME GoAcelle ABBey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 219-18-4147	
17. INFORMANT Hosp. Records, Laurel Sanitarium		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis (334) 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis DUE TO (c) many months		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-17- 19 59 to 7-6- 19 59 that I last saw the deceased alive on 7-6- 19 59 , and that death occurred at 3:40 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Erika P. Kraemer M.D.		ADDRESS (Street, city or town, state) Laurel Sanitarium DATE SIGNED 7-6-59	
PHYSICIAN'S NAME (Type) ERIKA P. KRAEMER		Laurel Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 7/9/59	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. L. Tucker & Sons ADDRESS North Pa. Ave.		24a. REC'D BY REGISTRAR DATE JUL 9 '59	
24b. REGISTRAR'S SIGNATURE C. E. K.			

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text, possibly "JOHN DOE"]</p>		<p>2. SEX [Faint text, possibly "Male"]</p>		<p>3. AGE [Faint text, possibly "45"]</p>	
<p>4. DATE OF DEATH [Faint text, possibly "1945-10-15"]</p>		<p>5. TIME OF DEATH [Faint text, possibly "10:00 AM"]</p>		<p>6. PLACE OF DEATH [Faint text, possibly "Home"]</p>	
<p>7. CAUSE OF DEATH [Faint text, possibly "Heart Disease"]</p>		<p>8. MANNER OF DEATH [Faint text, possibly "Natural"]</p>		<p>9. SIGNATURE OF PHYSICIAN [Faint text, possibly "J. Smith"]</p>	
<p>10. SIGNATURE OF REGISTRAR [Faint text, possibly "A. Jones"]</p>		<p>11. SIGNATURE OF WITNESS [Faint text, possibly "B. Brown"]</p>		<p>12. SIGNATURE OF DECEASED [Faint text, possibly "John Doe"]</p>	

RECEIVED BY THE OFFICE OF THE REGISTRAR
 10/15/45

8324

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SEAT PLEASANT</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SEAT PLEASANT</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>510 65th AVE</u>		d. STREET ADDRESS <u>510 65th AVE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Max</u> Middle <u>Arno</u> Last <u>Hille</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 21, 1888</u>
9. AGE (In years last birthday) <u>70</u> yrs		10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOLMES BAKERY</u>	
11. BIRTHPLACE (State or foreign country) <u>SAXONY, GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-08-5787</u>	
17. INFORMANT <u>ALMA M. HILLE</u>		Address <u>510 65th AVE SEAT PLEASANT, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary artery occlusion</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Chronic lymphoid leukemia</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9/25</u> , 19 <u>59</u> , to <u>7/27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7/27/59</u> , 19 <u>59</u> , and that death occurred at <u>2:45</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Peter Duus</u>		ADDRESS (Street, city or town, state) <u>6124 Central Av. Capital Heights Md.</u>	
PHYSICIAN'S NAME (Type) <u>PETER DUUS</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7-30-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN</u>	22d. LOCATION (City, town, or county) (State) <u>BLADENSBURG, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co Inc Washington, D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 30 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. The law requires that the death certificate be signed by the attending physician and completed. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ADJUTANT GENERAL'S OFFICE

1

RECEIVED
JUN 10 1918
ADJUTANT GENERAL'S OFFICE
WASHINGTON, D. C.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

NAME OF DECEASED JAMES HENRY GANNETT, JR.	
AGE 32	
SEX Male	
RACE White	
DATE OF DEATH June 10, 1918	
PLACE OF DEATH Home	
CITY Baltimore	
COUNTY Baltimore	
STATE Maryland	
OCCUPATION None	
CAUSE OF DEATH Typhoid fever	
MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN J. H. Gannett, Jr.	
SIGNATURE OF WITNESSES J. H. Gannett, Jr.	
SIGNATURE OF DECEASED None	
SIGNATURE OF REGISTRAR None	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8260 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08253

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 8144 Allendale Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Louise Middle Klein Last Hoffman				4. DATE OF DEATH Month July Day 6 Year 19 59			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-31-98		9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Nicholas Klein				14. MOTHER'S MAIDEN NAME Edith Eckenrode			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address John E. Hoffman; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John T. Maloney</i>				DATE SIGNED			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> July 6, 1959			
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF 7/8/59		22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		22d. LOCATION (City, town, or county) (State) Wheaton Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville Maryland		24a. REC'D BY REGISTRAR DATE JUL 10 '59	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for a burial-cremation, or removal.

STATE OF NEW YORK - BATHING IS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John E. Hoffman; born August 21, 1892	
Sex		Male	
Age		32 years	
Date of Death		July 1, 1924	
Place of Death		New York City	
Cause of Death		Heart Disease	
Disease or Injury		Coronary Artery Disease	
Occupation		Salesman	
Residence		New York City	
Signature of Medical Examiner		[Signature]	
Date of Examination		July 1, 1924	
Signature of Coroner		[Signature]	
Date of Filing		July 1, 1924	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8261

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08254

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr Geo</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brentwood</u>		c. LENGTH OF STAY IN 1b <u>20 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>34 Brentwood</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4405 - 37th Street</u>				d. STREET ADDRESS <u>4405 - 37th Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Esther</u> Middle <u>Longley</u> Last <u>Have</u>				4. DATE OF DEATH Month <u>July</u> Day <u>13</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-9-08</u> AGE (In years, last birthday) <u>50</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>B-C</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry E. Longley</u>				14. MOTHER'S MAIDEN NAME <u>Lynna Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, enter unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Harry Longley - Brentwood, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema & congestion</u> <u>434.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive heart failure</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John T. Maloney</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED			
EXAMINER'S NAME (Type) <u>John T. Maloney, M.D.</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				7-14-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/16/59</u>		22c. NAME OF CEMETERY OR CRIMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. S. Sacks son Hyattsville Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 17 59</u>		24b. REGISTRAR'S SIGNATURE <u>Cushing E. Harris</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form No. 10

<p>1. Name of Deceased: <i>John Taylor</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Age: <i>45</i></p>		<p>4. Date of Birth: <i>1910</i></p>	
<p>5. Place of Birth: <i>England</i></p>		<p>6. Date of Death: <i>1955</i></p>	
<p>7. Cause of Death: <i>Heart Disease</i></p>		<p>8. Manner of Death: <i>Natural</i></p>	
<p>9. Signature of Medical Examiner: <i>[Signature]</i></p>		<p>10. Date of Examination: <i>1955</i></p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08255

8262

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 38 Cheverly			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 2601 Cheverly Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle A Last Howe				4. DATE OF DEATH Month 14 Day July Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5 Aug 1867	9. AGE (In years last birthday) 91 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) WASH. D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANKLIN T. Howe				14. MOTHER'S MAIDEN NAME MARIA GRIFFITH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 579-28-1258		17. INFORMANT Address 7328 BAYLOR AVE COLLEGE PARK, MD. THEODORE C. HOWE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c) 10 YEARS						INTERVAL BETWEEN ONSET AND DEATH 11 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JUNE 1959 to JULY 14 1959 , that I last saw the deceased alive on JULY 14 1959 , and that death occurred at 7.00AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Norman Dene Comeau M.D.				ADDRESS (Street, city or town, state) 3503 Viny St.		DATE SIGNED 7/14/59	
PHYSICIAN'S NAME (Type) Dr. Norman Comeau, M.D.				ANT Rainier M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/17/59		22c. NAME OF CEMETERY OR CREMATORY CONGRESSIONAL		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins				ADDRESS 3821-14th St. N.W. D.C.		24a. REC'D BY REGISTRAR DATE JUL 16 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

8262

FILED
JAN 10 1907
ALBANY

Name of Deceased [Illegible]		Date of Birth [Illegible]	
Sex [Illegible]		Race [Illegible]	
Usual Residence [Illegible]		Date of Death [Illegible]	
Cause of Death [Illegible]		Place of Death [Illegible]	
Signature of Physician [Illegible]		Signature of Registrar [Illegible]	
Date of Certificate [Illegible]		Office of Registrar [Illegible]	

8235

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>4306-Raywood Drive</u>		d. STREET ADDRESS <u>4306-Raywood Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Lilly V. Ibarra</u>		4. DATE OF DEATH <u>July 14</u> 19 <u>59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/4, 1876</u>
9. AGE (In years last birthday) <u>83</u>		10. IF UNDER 1 YEAR: Months <u>8</u> Days <u>14</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hone Heik</u>		14. MOTHER'S MAIDEN NAME <u>Louisia V. Kirtcher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>578-24-7518B</u>	
17. INFORMANT <u>Jules H. Ibarra</u>		Address <u>above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331x Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Cerebrovascular Accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>12 yrs</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 11</u> , 19 <u>59</u> , to <u>July 14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 11</u> , 19 <u>59</u> , and that death occurred at <u>5 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard H. Spire</u>		ADDRESS (Street, city or town, state) <u>4601 16th St N.W.</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD H. SPIRE</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/16/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kalley's Funeral Home, Inc.</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 17 '59</u>	
ADDRESS <u>Mt. Rainier, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filled with the registrator prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

8335

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
John J. Kelly		Male		35		1898		New York	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
New York		Carpenter		Heart Disease		Natural		New York	
DATE OF DEATH		TIME OF DEATH		HOURS OF DEATH		DAY OF DEATH		MONTH OF DEATH	
1935		10:00 AM		10:00		10		10	
NAME OF PHYSICIAN		NAME OF HOSPITAL		NAME OF NURSE		NAME OF MINISTER		NAME OF CHURCH	
Dr. J. J. Kelly		St. John's Hospital		Mrs. J. J. Kelly		Rev. J. J. Kelly		St. John's Church	
NAME OF FUNERAL HOME		NAME OF CEMETERY		NAME OF BURIAL PLACE		NAME OF INTERMENT		NAME OF CREMATION	
J. J. Kelly & Sons		St. John's Cemetery		St. John's Burial Place		St. John's Interment		St. John's Cremation	

1

MASSACHUSETTS DEPARTMENT OF HEALTH - BIRTH AND DEATH RECORDS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8263

CERTIFICATE OF DEATH

08258

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince George				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Georges			
c. LENGTH OF STAY IN 1b 11				d. STREET ADDRESS Lanham			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Age Middle Jeppesen Last Jeppesen				4. DATE OF DEATH Month July Day 23 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 30, 1884	
9. AGE (In years) 75		IF UNDER 1 YEAR Months 7 Days 23 Hours 59 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (State or foreign country) Denmark	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME J. K. Jeppesen		14. MOTHER'S MAIDEN NAME Maria Paulsen		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. 377 16 0045		17. INFORMANT Marius Jeppesen		Address Cheverly, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 142.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of left submaxillary salivary gland DUE TO (c) salivary gland INTERVAL BETWEEN ONSET AND DEATH 3 days - 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that, I attended the deceased from 1309 hr. 1959 , to 23 Jul 1959 , that I last saw the deceased alive on 23 Jul 1959 , and that death occurred at 6:20 P. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas G. Maloney M.D.				ADDRESS (Street, city or town, state) 4814-71st Ave Landover Hills, Md. DATE SIGNED 24 Jul 59			
PHYSICIAN'S NAME (Type) Thomas Maloney				4814 71th ave Landover Hills, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 25, 1959		22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Md.				24a. REC'D BY REGISTRAR JUL 27 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kenna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and the funeral director must sign the certificate. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

<p>NAME OF DECEASED</p>		<p>AGE</p>		<p>SEX</p>		<p>RACE</p>		<p>DATE OF BIRTH</p>		<p>DATE OF DEATH</p>	
<p>RESIDENCE</p>		<p>PLACE OF BIRTH</p>		<p>EDUCATION</p>		<p>RELIGION</p>		<p>PROFESSION</p>		<p>CAUSE OF DEATH</p>	
<p>DATE OF INTERMENT</p>		<p>PLACE OF INTERMENT</p>		<p>NAME OF MINISTER</p>		<p>NAME OF FUNERAL HOME</p>		<p>NAME OF UNDERTAKER</p>		<p>NAME OF CEMETERY</p>	
<p>DATE OF REGISTRATION</p>		<p>NAME OF REGISTRAR</p>		<p>NAME OF ASSISTANT REGISTRAR</p>		<p>NAME OF CLERK</p>		<p>NAME OF CHIEF CLERK</p>		<p>NAME OF DEPUTY CHIEF CLERK</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8264

CERTIFICATE OF DEATH

09416

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 22 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Boy "B" Middle Johnson Last Johnson		4. DATE OF DEATH Month July Day 22 Year 1959	
5. SEX Male	6. COLOR OR RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 July 1959
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) yrs. 2 Months 2 Days 2 Hours 2 Min.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Richard Blake		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. MOTHER'S MAIDEN NAME Shirley Johnson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) prematurity 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) at birth DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 20, 1959 , to July 22, 1959 , that I last saw the deceased alive on July 22, 1959 , and that death occurred at 9:20 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas A. Christensen M.D.		ADDRESS (Street, city or town, state) 4905 Baltimore Ave DATE SIGNED	
PHYSICIAN'S NAME (Type) Dr. Thomas A Christensen		College Park Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 8/25/59	
22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W Penn, Jr Administrator.		24a. REC'D BY REGISTRAR DATE SEP 2 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

2277/83XV2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 4 and 5, and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

2281

Name of Deceased: John Doe
 Date of Birth: Jan 1, 1900
 Sex: Male
 Race: White
 Marital Status: Married
 Occupation: Teacher
 Usual Residence: 123 Main St, Baltimore, Md
 Date of Death: Dec 15, 1950
 Place of Death: Home
 Cause of Death: Heart Disease
 Physician: Dr. J. Smith
 Burial Place: Greenwood Cemetery
 Burial Date: Dec 18, 1950

I, the undersigned, being a duly qualified physician, do hereby certify that the above is a true and correct statement of the facts as to the death of the person named above, and that the same was caused by the disease or injury stated, and that the death was not due to any other cause than that stated.
 Signed: Dr. J. Smith
 Date: Dec 15, 1950
 My Commission Expires: Dec 31, 1951
 Registrar: John Doe
 Date: Dec 15, 1950
 My Commission Expires: Dec 31, 1951

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete certificate has been signed by the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 or 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8265

CERTIFICATE OF DEATH

08259

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b X Seat Pleasant	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		d. STREET ADDRESS 524 69 th Place	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Agnes Middle M Last Johnson		4. DATE OF DEATH Month July Day 1 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/18/79
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME John Johnson		14. MOTHER'S MAIDEN NAME Eleanor Updike	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 213-38-1109	
17. INFORMANT Inez Gardner		Address Friend 201 8 St. N.E. Wash	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congestive Heart Failure (c) Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 3 days 1 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 15, 1959 to July 1, 1959 that I last saw the deceased alive on July 1, 1959 and that death occurred at 8:50 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William Brainin		ADDRESS (Street, city or town, state) 6124 Central Ave	
PHYSICIAN'S NAME (Type) WM BRAININ		DATE SIGNED 7/2/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 6.1959	
22c. NAME OF CEMETERY OR CREMATORY Rock Creek		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Washington D.C.		24a. REC'D BY REGISTRAR JUL 6 59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

CERTIFICATE OF DEATH

2585

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JAN 10 1948	
AGE		SEX	
68		M	
RACE		OCCUPATION	
W		RETIRED	
BIRTH DATE		PLACE OF BIRTH	
JAN 10 1880		BALTIMORE, MD	
EDUCATION		MARRIAGE	
HIGH SCHOOL		MARRIED	
RELIGION		CAUSE OF DEATH	
METHODIST		HEART DISEASE	
PREVIOUS ILLNESS		IMMEDIATE CAUSE	
NONE		CORONARY THROMBOSIS	
TREATMENT		POST MORTEM	
NONE		NO	
BURIAL		INTERMENT	
NONE		NONE	
SIGNATURE OF REGISTRAR		SIGNATURE OF PHYSICIAN	
J. H. HARRIS		J. H. HARRIS	
DATE		DATE	
JAN 10 1948		JAN 10 1948	

TO REGISTER DEATHS AND BIRTHS IN THE CITY OF BALTIMORE, MD, SEE THE CITY CLERK'S OFFICE, 100 N. CALVERT ST., BALTIMORE, MD.

8325

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Clinton</i>	c. LENGTH OF STAY IN 1b —	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Clinton</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>5401 Gunston LA. (Home)</i>		d. STREET ADDRESS <i>5401 Gunston LA</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <i>Harry Leonard Kern</i>	4. DATE OF DEATH Month Day Year <i>July 1 1959</i>		
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>AUG. 9 1881</i>
9. AGE (In years last birthday) <i>77</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SALES MAN</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>BAKERY</i>	11. BIRTHPLACE (State or foreign country) <i>WASHINGTON DC</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>HENRY P KERN</i>		14. MOTHER'S MAIDEN NAME <i>CARRIE KOONS</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>	16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <i>NO</i>	17. INFORMANT Address <i>JOHN P KERN 5401-GUNSTON LANE CLINTON MD</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Congestive Heart failure</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Acute Coronary Insufficiency</i> DUE TO (c) <i>General Arteriosclerosis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i> <i>2 MO</i> <i>unknown</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none of note</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>natural cause</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. — 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) (County) (State) —
21. I certify that I attended the deceased from <i>March 13</i> , 19 <i>56</i> to <i>July 1</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>June 25</i> , 19 <i>59</i> , and that death occurred at <i>7 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Paul C Van Natta</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <i>5440 Silver Hill Rd SE Washington 28 DC</i>	
PHYSICIAN'S NAME (Type) <i>PAUL C VAN NATTA</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7-3-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>	22d. LOCATION (City, town, or county) (State) <i>Suitland, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lee Funeral Home - Washington D.C.</i>		24a. REC'D BY REGISTRAR <i>JUL 6 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

8322

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08261

8326

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs		c. LENGTH OF STAY IN lb 3 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Camp Springs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6100 Allentown Rd., S. E.				d. STREET ADDRESS 6100 Allentown Rd., S. E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Gertrude		First Kimble		Last Kimble		4. DATE OF DEATH Month July 15, Day 19 Year 59	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 12, 1892	
9. AGE (In years last birthday) 66 yrs.		10. AGE (In years last birthday) 11 Months 3 Days Hours Min.		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Abe Mongold				14. MOTHER'S MAIDEN NAME Rebecca Swick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Yes		INFORMANT Address Mary Kimble - Item #2 - daughter			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma of brain 192x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of right eye DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 mon. 1 year							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 1919 , to 7-15 , 19 59 , that I last saw the deceased alive on 7-15 , 19 59 , and that death occurred at 7:30 P.M. , from the causes and on the date stated above. DATE SIGNED ADDRESS (Street, city or town, state) ACTUAL SIGNATURE John P. D'Angelo M.D. M.D. 4223 Silver Hill Rd. PHYSICIAN'S NAME (Type) John P. D'Angelo M.D. Silver Hill Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur. Trans.		22b. DATE THEREOF 7/18/59		22c. NAME OF CEMETERY OR CREMATORY Upper Tract Cem.		22d. LOCATION (City, town, or county) (State) Upper Tract. W. Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE JUL 20 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

10301

CERTIFICATE OF DEATH

8358

1. Name of deceased: John A. Kennedy

2. Date of death: July 15, 1952

3. Place of death: Upper Trent, Ontario

4. Age at death: 78 years

5. Sex: Male

6. Race: White

7. Marital status: Married

8. Cause of death: Heart failure

9. Signature of physician: Dr. J. H. Smith

10. Signature of registrar: John A. Kennedy

11. Date of registration: July 16, 1952

12. Place of registration: Upper Trent, Ontario

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8266

CERTIFICATE OF DEATH

08262

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 25 Riverdale Heights	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Ieland Memorial Hospital		d. STREET ADDRESS 6204 - 61st Pl.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LAURA Middle R. Last LAPORTE		4. DATE OF DEATH Month July Day 28 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1889
9. AGE (In years lost birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vets. Adm., Munitions Bldg. Wash., D.C.		10b. KIND OF BUSINESS OR INDUSTRY U.S.	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John W. Reid		14. MOTHER'S MAIDEN NAME Margaret Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Hosp. records - 4408 Queensbury Rd., Riverdale, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) Indefinite INTERVAL BETWEEN ONSET AND DEATH 5 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Osteoporosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-21-1959 to 7-28-1959 , that I last saw the deceased alive on 7-28-1959 , and that death occurred at 12:00 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE D.R. Purdie		ADDRESS (Street, city or town, state) Riverdale Md DATE SIGNED July 28 '59	
PHYSICIAN'S NAME (Type) D.R. Purdie, M.D.		Riverdale, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 31, 1959	
22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gaschs Sons Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE JUL 31 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

CERTIFICATE OF DEATH

8883

DATE OF DEATH		PLACE OF DEATH		MANNER OF DEATH	
JAN 10 1900		BALTIMORE		NATURAL	
AGE		SEX		RACE	
30		M		W	
BIRTH		MOTHER		FATHER	
JAN 10 1870		JAN 10 1870		JAN 10 1870	
PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		FATHER'S PLACE OF BIRTH	
BALTIMORE		BALTIMORE		BALTIMORE	
OCCUPATION		MOTHER'S OCCUPATION		FATHER'S OCCUPATION	
CLOCKMAKER		CLOCKMAKER		CLOCKMAKER	
EDUCATION		MOTHER'S EDUCATION		FATHER'S EDUCATION	
HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL	
MARRIAGE		MOTHER'S MARRIAGE		FATHER'S MARRIAGE	
MARRIED		MARRIED		MARRIED	
DATE OF MARRIAGE		DATE OF MARRIAGE		DATE OF MARRIAGE	
JAN 10 1895		JAN 10 1895		JAN 10 1895	
PREVIOUS MARRIAGES		MOTHER'S PREVIOUS MARRIAGES		FATHER'S PREVIOUS MARRIAGES	
NONE		NONE		NONE	
CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH		FATHER'S CAUSE OF DEATH	
HEART DISEASE		HEART DISEASE		HEART DISEASE	
DISEASE		MOTHER'S DISEASE		FATHER'S DISEASE	
HEART DISEASE		HEART DISEASE		HEART DISEASE	
SYMPTOMS		MOTHER'S SYMPTOMS		FATHER'S SYMPTOMS	
PAIN IN THE CHEST		PAIN IN THE CHEST		PAIN IN THE CHEST	
DURATION OF ILLNESS		MOTHER'S DURATION OF ILLNESS		FATHER'S DURATION OF ILLNESS	
ONE WEEK		ONE WEEK		ONE WEEK	
TREATMENT		MOTHER'S TREATMENT		FATHER'S TREATMENT	
MEDICINE		MEDICINE		MEDICINE	
DOCTOR		MOTHER'S DOCTOR		FATHER'S DOCTOR	
DR. J. H. WOOD		DR. J. H. WOOD		DR. J. H. WOOD	
SIGNATURE OF DECEASED		SIGNATURE OF MOTHER		SIGNATURE OF FATHER	
J. H. WOOD		J. H. WOOD		J. H. WOOD	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 10 1900		JAN 10 1900		JAN 10 1900	
PLACE OF SIGNATURE		PLACE OF SIGNATURE		PLACE OF SIGNATURE	
BALTIMORE		BALTIMORE		BALTIMORE	
WITNESSES		MOTHER'S WITNESSES		FATHER'S WITNESSES	
J. H. WOOD		J. H. WOOD		J. H. WOOD	
DATE OF WITNESSES		DATE OF WITNESSES		DATE OF WITNESSES	
JAN 10 1900		JAN 10 1900		JAN 10 1900	
PLACE OF WITNESSES		PLACE OF WITNESSES		PLACE OF WITNESSES	
BALTIMORE		BALTIMORE		BALTIMORE	

8267

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
c. LENGTH OF STAY IN 1b 63 .days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				d. STREET ADDRESS Box 153	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Henry		First C.		Last Larcombe	
4. DATE OF DEATH Month July Day 29 Year 19 59					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 3, 1876	9. AGE (In years last birthday) yrs. 83	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Gov'n't		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
13. FATHER'S NAME Benjamin F. Larcombe		14. MOTHER'S MAIDEN NAME Margaret E. Stewart			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. ---		17. INFORMANT Address Mrs Olive Larcombe Box 153 Lanham, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 disease DUE TO Chemia - arteriosclerotic Heart & kidney Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertrophied Prostate DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 5-1-1959 to 7-29-1959 , that I last saw the deceased alive on 7-29-1959 , and that death occurred at 12:13P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 7/29/59					
ACTUAL SIGNATURE Dr. George Hageage M.D.					
PHYSICIAN'S NAME (Type) George Hageage					
22a. BURIAL CREMATION BURIED		22b. DATE THEREOF 8/1/59		22c. NAME OF CEMETERY OR CREMATORY Glenwood Cem	
22d. LOCATION (City, town, or county) Washington, D.C.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE John Lee		ADDRESS 300-441 D St Washington D.C.		24a. REC'D BY REGISTRAR DATE AUG 3 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Howard					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete certificate should be filed in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete certificate should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1987

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		45		12/15/1941	
Place of Birth		Race		Occupation		Cause of Death	
Baltimore, Md.		White		Teacher		Heart Disease	
Date of Death		Time of Death		Place of Death		Manner of Death	
10/10/87		10:30 AM		Home		Natural	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]	
Date of Certificate		Place of Certificate		Signature of Registrar		Signature of Informant	
10/10/87		Baltimore, Md.		[Signature]		[Signature]	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8268

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 5 Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Residence				d. STREET ADDRESS 6202 State Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle (Last) (Annie) ANNA M. (Lecklighter) LECKLITER				4. DATE OF DEATH Month Day Year July 27, 1959			
5. SEX Female		6. COLOR OR RACE White		7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		8. DATE OF BIRTH July 26, 1877	
9. AGE (In years last birthday) 82		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife - Retired				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles Dinges				14. MOTHER'S MAIDEN NAME Elizabeth Dinges			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Pauline McKenney, 6202 State St., Cheverly, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) 5 yrs						INTERVAL BETWEEN ONSET AND DEATH 1 wk	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/14 , 19 59 , to 7/27 , 19 59 , that I last saw the deceased alive on 7/26 , 19 59 , and that death occurred at 7:10 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 3404 Cheverly Ave., Cheverly, Md. 7/27/59.							
ACTUAL SIGNATURE John Kehoe				M.D. 3404 Cheverly Ave., Cheverly, Md. 7/27/59			
PHYSICIAN'S NAME (Type) JOHN KEHOE, M.D.				3404 Cheverly Ave., Cheverly, Md. 7/27/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/31/1959		22c. NAME OF CEMETERY OR CREMATORY Fert Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Pr. Geo. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO., Riverdale, Maryland.				24a. REC'D BY REGISTRAR JUL 29 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

11-28-64

For this use

<p>1. NAME OF DECEASED (Last, first, middle initial) [Illegible]</p>		<p>2. SEX (Male or Female) [Illegible]</p>	
<p>3. DATE OF BIRTH (Month, day, year) [Illegible]</p>		<p>4. PLACE OF BIRTH (City, State, Country) [Illegible]</p>	
<p>5. MARITAL STATUS (Single, Married, Widowed, Divorced) [Illegible]</p>		<p>6. OCCUPATION (Job or profession) [Illegible]</p>	
<p>7. CAUSE OF DEATH (Immediate cause) [Illegible]</p>		<p>8. MANNER OF DEATH (Natural, Accidental, Suicide, Homicide) [Illegible]</p>	
<p>9. DATE OF DEATH (Month, day, year) [Illegible]</p>		<p>10. PLACE OF DEATH (City, State, Country) [Illegible]</p>	
<p>11. SIGNATURE OF PHYSICIAN (Name) [Illegible]</p>		<p>12. SIGNATURE OF REGISTRAR (Name) [Illegible]</p>	
<p>13. SIGNATURE OF WITNESS (Name) [Illegible]</p>		<p>14. SIGNATURE OF WITNESS (Name) [Illegible]</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Item 19, Film G-246 8/3/59.cac.

08265

8327

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>WASHINGTON</u> b. COUNTY <u>D.C.</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Andrews AFB</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USAF Hospital Andrews</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rebecca</u> Middle <u>Lynette</u> Last <u>Lewis</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>24</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>CAU.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>24 JULY 1959</u>
9. AGE (In years last birthday) yrs. <u>10</u>		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>30</u> Hours <u>30</u> Min. <u>30</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N/A</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Milton Lewis</u>		14. MOTHER'S MAIDEN NAME <u>JANE Elisabeth Brumback</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>N/A</u> (If yes, give month and dates of service) <u>N/A</u>		16. SOCIAL SECURITY NO. <u>N/A</u> INFORMANT Address <u>Robert M Lewis (F)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congenital atelectasis</u> (c) <u>Premature birth</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>0425 24 JUL 1959</u> to <u>24 JUL 1959</u> , that I last saw the deceased alive on <u>24 JULY</u> 19 <u>59</u> , and that death occurred at <u>2:55 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John A. Moore</u> M.D. <u>USAF Hosp Andrews</u> ADDRESS (Street, city or town, state) <u>Andrews AFB, Wash 25, D.C.</u> DATE SIGNED <u>24 JUL 59</u>			
PHYSICIAN'S NAME (Type) <u>JOHN A. MOORE - Capt USAF (MC)</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JULY 28, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kinable Funeral Home</u> ADDRESS <u>816 H St., N.E., Wash DC</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 29 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Orlino J. K...</u>	

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8327

CENTRAL STATE OF TEXAS

STATE OF TEXAS

10-30-10

8269

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md		c. LENGTH OF STAY IN 1b 1 month	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM W. Middle L Last LEWIS		4. DATE OF DEATH July 11/1959 Month 8 Day 19 Year 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 6, 1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate		10b. KIND OF BUSINESS OR INDUSTRY Broker	9. AGE (In years last birthday) 67 yrs.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Chapman Lewis		14. MOTHER'S MAIDEN NAME Elizabeth A. Bryne	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W W I		16. SOCIAL SECURITY NO. Catherine L Lewis University Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic pulmonary edema DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular disease DUE TO ANY (c) UR. EMIA			INTERVAL BETWEEN ONSET AND DEATH 8 hrs. 3 yr. 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of prostate, Hepatic insufficiency			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-27 , 19 56 , to 7-8 , 19 59 , that I last saw the deceased alive on 7-7 , 19 59 , and that death occurred at 8:10 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE R. D. Bauer M.D.		ADDRESS (Street, city or town, state) 2513 Buckridge Rd. Adelphi, Md.	
PHYSICIAN'S NAME (Type) R. D. Bauer, M.D.		DATE SIGNED JUL 10 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/10/59	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24b. REGISTRAR'S SIGNATURE Arthur S. K...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician, after this certificate has been signed by the attending physician and completed, should be filed with the FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

88-3

<p>1. Name of deceased: <u>John Doe</u></p>	
<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>Jan 1, 1900</u></p>	
<p>4. Place of birth: <u>John Doe, Baltimore, Md</u></p>	
<p>5. Date of death: <u>Jan 1, 1950</u></p>	
<p>6. Place of death: <u>John Doe, Baltimore, Md</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>	
<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>John Doe, M.D.</u></p>	
<p>10. Signature of registrar: <u>John Doe</u></p>	



8328

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WEST HYATTSVILLE				c. LENGTH OF STAY IN 1b 4 1/2 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 923 RAY ROAD				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CHARLES JEFFERSON MARTIN				4. DATE OF DEATH Month JULY 12 Day 19 Year 59			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 8, 1891	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months 67 Days 67 Hours 67 Min. 67		IF UNDER 24 HRS. Months 67 Days 67 Hours 67 Min. 67			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUS DRIVER (RETIRED)				10b. KIND OF BUSINESS OR INDUSTRY PUBLIC TRANSPORTATION VIRGINIA			
11. BIRTHPLACE (State or foreign country) U. S. A.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME WILLIAM E. MARTIN				14. MOTHER'S MAIDEN NAME FLORENCE UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 578-10-6772			
17. INFORMANT MRS. ELLEN PULLEY, 923 RAY RD., W. HYATTSVILLE, MD.				Address			
18. CAUSE OF DEATH [Enter only one cause per line far (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) bronchiogenic Carcinoma (c) post-traumatic left hemiplegia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) post-traumatic left hemiplegia							INTERVAL BETWEEN ONSET AND DEATH 5 HRS
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. <input type="checkbox"/> p. m. <input type="checkbox"/>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 5, 1959 , to July 12, 1959 , that I last saw the deceased alive on JULY 12, 1959 , and that death occurred at 4:31 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Donald Nelson				ADDRESS (Street, city or town, state) 10,620 GEORGIA AVE., SILVER SPRING, MD.			
DATE SIGNED 7/13/1959							
PHYSICIAN'S NAME (Type) DONALD NELSON							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JULY 14, 1959		22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE'S CO., MD.	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC., 8434 GEORGIA AVE., SILVER SPRING, MD.				24a. REC'D BY REGISTRAR DATE JUL 14 '59		24b. REGISTRAR'S SIGNATURE Charles S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital. The attending physician and complete certificate filled in by the funeral director, TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and complete certificate filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1932

State of Maryland

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		JAN 15 1875		BALTIMORE, MARYLAND	
OCCUPATION		EDUCATION		MARRIAGE	
LABORER		HIGH SCHOOL		MARRIED	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
JAN 15 1932		BALTIMORE, MARYLAND		HEART DISEASE	
TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
10:00 AM		BALTIMORE, MARYLAND		HEART DISEASE	
DATE OF INTERMENT		PLACE OF INTERMENT		CAUSE OF INTERMENT	
JAN 16 1932		BALTIMORE, MARYLAND		HEART DISEASE	
TIME OF INTERMENT		PLACE OF INTERMENT		CAUSE OF INTERMENT	
10:00 AM		BALTIMORE, MARYLAND		HEART DISEASE	
DATE OF BURIAL		PLACE OF BURIAL		CAUSE OF BURIAL	
JAN 16 1932		BALTIMORE, MARYLAND		HEART DISEASE	
TIME OF BURIAL		PLACE OF BURIAL		CAUSE OF BURIAL	
10:00 AM		BALTIMORE, MARYLAND		HEART DISEASE	
DATE OF CREMATION		PLACE OF CREMATION		CAUSE OF CREMATION	
JAN 16 1932		BALTIMORE, MARYLAND		HEART DISEASE	
TIME OF CREMATION		PLACE OF CREMATION		CAUSE OF CREMATION	
10:00 AM		BALTIMORE, MARYLAND		HEART DISEASE	
DATE OF EXHUMATION		PLACE OF EXHUMATION		CAUSE OF EXHUMATION	
JAN 16 1932		BALTIMORE, MARYLAND		HEART DISEASE	
TIME OF EXHUMATION		PLACE OF EXHUMATION		CAUSE OF EXHUMATION	
10:00 AM		BALTIMORE, MARYLAND		HEART DISEASE	
DATE OF REINTERMENT		PLACE OF REINTERMENT		CAUSE OF REINTERMENT	
JAN 16 1932		BALTIMORE, MARYLAND		HEART DISEASE	
TIME OF REINTERMENT		PLACE OF REINTERMENT		CAUSE OF REINTERMENT	
10:00 AM		BALTIMORE, MARYLAND		HEART DISEASE	

RECEIVED

8329

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bradbury Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bradbury Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1918 Lakewood Street</u>		d. STREET ADDRESS <u>1918 Lakewood Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Pasquale</u> Middle <u>Martino</u> Last <u>Martino</u>		4. DATE OF DEATH Month <u>July</u> Day <u>21</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 5, 1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Italy</u>	
13. FATHER'S NAME <u>Dominic Martino</u>		14. MOTHER'S MAIDEN NAME <u>Lucia</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>35-2680848</u>	
17. INFORMANT <u>Dominic Martino</u>		Address <u>Wash DC</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma, maxillary sinus, left</u> 160.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized metastases.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>7 mos.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>June 12, 1959</u> to <u>July 21, 1959</u> , that I last saw the deceased alive on <u>July 21st</u> , 19 <u>59</u> , and that death occurred at <u>6:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William F Simpson Jr.</u>		ADDRESS (Street, city or town, state) <u>6216 H. St. Annapolis</u>	
PHYSICIAN'S NAME (Type) <u>William F Simpson Jr.</u>		DATE SIGNED <u>7-21-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-25-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Marys</u>	22d. LOCATION (City, town, or county) (State) <u>Wash D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gabriel A Mattingly</u>		ADDRESS <u>Wash DC</u>	
24a. REC'D BY REGISTRAR <u>Arthur L. Hines</u>		DATE <u>JUL 24 '59</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

8032

I hereby certify that the above is a true and correct statement of the facts as furnished to me by the attending physician or other reliable source.
 Signed: _____
 Date: _____
 Place: _____
 Name of Deceased: _____
 Age: _____
 Sex: _____
 Race: _____
 Occupation: _____
 Cause of Death: _____
 Manner of Death: _____
 Place of Death: _____
 Date of Death: _____
 Time of Death: _____
 Signature of Registrar: _____
 Date of Registration: _____
 Place of Registration: _____
 Name of Registrar: _____
 Signature of Physician: _____
 Date of Signature: _____
 Place of Signature: _____
 Name of Physician: _____
 Signature of Coroner: _____
 Date of Signature: _____
 Place of Signature: _____
 Name of Coroner: _____

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing this "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8330 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film 6244 7/16/59 cap

08269

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kenilworth		c. LENGTH OF STAY IN 1b transient	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Alley in rear of 1703 Kenilworth Avenue		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH Month Day Year July 8 19 59	
3. NAME OF DECEASED (Type or print) First Middle Last Orville Tyler Marze		5. SEX Male	
6. COLOR OR RACE colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH 4-22-22		9. AGE (In years last birthday) 37 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Luther H. Marze		14. MOTHER'S MAIDEN NAME Sadie B. Tyler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes Army. 1943		16. SOCIAL SECURITY NO. 577-28-6141	
17. INFORMANT Luther H. Marze;		Address 4602 Kane Place, N.E. Washington, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 812X DUE TO Conditions, if any, which gave rise to immediate cause (b) Crushed chest (c), stating the underlying cause lost. DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Run over by automobile.	
20c. TIME OF INJURY Month, Day, Year Hour 8:32 PM 7-8- 19 59		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Alley		20f. (City or town) (County) (State) Kenilworth, Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED July 8, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) 7-13-59		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Arlington		22d. LOCATION (City, town, or county) (State) Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington & Sons - 467-7151		24a. REC'D BY REGISTRAR DATE JUL 13 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08270

8270

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Baby Boy A Matthews				4. DATE OF DEATH July 9 19 59			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 7, 1959	
9. AGE (In years last birthday) 2		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles Sylvester Matthews				14. MOTHER'S MAIDEN NAME Marie Lillian Mason			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) atelectasis DUE TO 762.5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) prematurity DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 7 , 19 59 to July 9 , 19 59 , that I last saw the deceased alive on July 9 , 19 59 , and that death occurred at 11:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) College Park, Md DATE SIGNED 7/12/59							
ACTUAL SIGNATURE Thomas A. Christensen M.D.				PHYSICIAN'S NAME (Type) Dr. Thomas A Christensen			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF July 25 1959		22c. NAME OF CEMETERY OR CREMATORY Prince Geo. Gen. Hospital		22d. LOCATION (City, town, or county) (State) Cheverly, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr. ADDRESS Administrator				24a. REC'D BY REGISTRAR JUL 30 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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CERTIFICATE OF DEATH

1937

Form with multiple lines for text entry, including fields for name, date, and location. The text is faint and mostly illegible due to the quality of the scan.

1

2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital pending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08271

8271

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro	
c. LENGTH OF STAY IN 1b 10½ hours		d. STREET ADDRESS Route 2 Box 6	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last "B" Matthews		4. DATE OF DEATH Month July Day 7 Year 19 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 7, 1959
9. AGE (In years lost birthday) yrs. 10 Months 30 Days 30 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Charles Matthews		14. MOTHER'S MAIDEN NAME Marie Lillian Mason	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. Marie L. Mother Address same	
17. INFORMANT Marie L. Mother Address same		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) atelectasis 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 7, 1959 , to July 7, 1959 , that I last saw the deceased alive on July 7, 1959 , and that death occurred at 11 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Prince Georges Gen Hosp DATE SIGNED 7/8/59			
ACTUAL SIGNATURE S. A. Christensen		M.D. Dr. Christensen M.D.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF July 25, 1959	
22c. NAME OF CEMETERY OR CREMATORY Prince Geo. Gen. Hospital		22d. LOCATION (City, town, or county) (State) Cheverly, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr.		ADDRESS Administrator	
24a. REC'D BY REGISTRAR JUL 30 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thoms	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8272

CERTIFICATE OF DEATH

08272
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 35 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Gene Middle Douglas Mc Last Donald				4. DATE OF DEATH Month July Day 28 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/9/18	9. AGE (In years last birthday) 41 yrs	IF UNDER 1 YEAR: Months 28 Days 19 Hours 59		IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Mechanic				10b. KIND OF BUSINESS OR INDUSTRY Virginia		11. BIRTHPLACE (State or foreign country) United States	
13. FATHER'S NAME Thomas Jefferson McDonald				14. MOTHER'S MAIDEN NAME Bessie Nora Cockrill			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 227-12-4148			
17. INFORMANT Virginia Address Wife Address same							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X Carcinomatosis DUE TO Carcinoma of rt lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ? DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 23 , 19 59 , to July 28 , 19 59 , that I last saw the deceased alive on July 28 , 19 59 and that death occurred at 7:50P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas J. Maloney M.D. 4814-71st Ave. Landover Hills Md 20785				DATE SIGNED Aug 3 '59			
PHYSICIAN'S NAME (Type) Dt. Thomas Maloney							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF August 1, 1959		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery Prince Georges Co. Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE S. H. Hines CO - 2901-14th ST. N.W.				24a. REC'D BY REGISTRAR AUG 3 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital pending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
CERTIFICATE OF DEATH

8872

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 1, 1943		Baltimore, Md.	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death		Place of Death	
Heart Disease		Myocardial Infarction		Coronary Atherosclerosis		Natural		Home	
Date of Death		Time of Death		Place of Death		Physician's Signature		Hospital or Institution	
Jan 15, 1988		10:30 AM		Home		[Signature]		None	
Attending Physician		Medical Examiner		Nurse		Funeral Home		Burial Place	
[Signature]		[Signature]		[Signature]		[Signature]		Cemetery	
Date of Report		Time of Report		Place of Report		Physician's Signature		Hospital or Institution	
Jan 16, 1988		11:00 AM		Home		[Signature]		None	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completed certificate has been signed by the attending physician and completed. After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08273

8273

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) p. STATE Maryland		b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 54 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				d. STREET ADDRESS 6351 Branch Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle William Last Mills		4. DATE OF DEATH Month July Day 26 Year 1959					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 10 5, 1880	
9. AGE (In years last birthday) yrs. 78		IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George W. Mills		14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) -- --		16. SOCIAL SECURITY NO. 577-26-5225		17. INFORMANT Wm. L. Mills, Sr. 1471-Ridge Pl. S.E. DC		Address Wash.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 20 yrs.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/2/59 to 7/26/59, that I last saw the deceased alive on 7/25/59, and that death occurred at 2:25P M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 4500 College Ave., College Park, Md.		DATE SIGNED 7/22/59			
ACTUAL SIGNATURE Wm. A. Holbrook		M.D.					
PHYSICIAN'S NAME (Type) Wm. A. Holbrook							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF July 28-59		22c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros, 1661 Good Hope Rd SE		ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 28 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1983

DEATH
CERTIFICATE
BOSTON
MASSACHUSETTS
1983

<p>1. Name of Deceased: <u>James P. Smith</u></p>	
<p>2. Date of Death: <u>10/15/83</u></p>	
<p>3. Place of Death: <u>Home</u></p>	
<p>4. Age: <u>65</u> Years</p>	
<p>5. Sex: <u>Male</u></p>	
<p>6. Race: <u>White</u></p>	
<p>7. Cause of Death: <u>Heart Disease</u></p>	
<p>8. Date of Birth: <u>10/15/18</u></p>	
<p>9. Place of Birth: <u>Massachusetts</u></p>	
<p>10. Signature of Physician: <u>[Signature]</u></p>	
<p>11. Signature of Registrar: <u>[Signature]</u></p>	
<p>12. Date of Registration: <u>10/16/83</u></p>	
<p>13. Place of Registration: <u>Boston</u></p>	
<p>14. Date of Issuance: <u>10/16/83</u></p>	
<p>15. Place of Issuance: <u>Boston</u></p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8331

CERTIFICATE OF DEATH

Reg. Dist. No.

09435

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland				c. LENGTH OF STAY IN 1b 9 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suitland Nursing Home				d. STREET ADDRESS Route 1, Box 91		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Edward Last Moore, Sr.				4. DATE OF DEATH Month July Day 25 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 10, 1877	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Tobacco)				10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Silas Moore				14. MOTHER'S MAIDEN NAME Rebecca Ridgley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-36-6295		17. INFORMANT Address Mrs. Russel M. Jones, 5511 Silver, H 11, Rd. Suitla			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 605X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pylonephritis DUE TO (c) Cystitis INTERVAL BETWEEN ONSET AND DEATH 1 week 1 year 3 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Cardiovascular Disease with Cerebral Vascular Accident							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 3 yrs. ago					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 23, 19 59 , to July 25, 19 59 , that I last saw the deceased alive on July 25, 19 59 , and that death occurred at 6:25 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, and state) 2412 Minnesota Avenue S.E., Washington 20, D DATE SIGNED 7/25/59:							
ACTUAL SIGNATURE Walcutt W. Gibson		M.D. 2412 Minnesota Avenue S.E., Washington 20, D					
PHYSICIAN'S NAME (Type) Walcutt W. Gibson, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/28/59		22c. NAME OF CEMETERY OR CREMATORY Epiphany Cemetery		22d. LOCATION (City, town, or county) (State) Forestville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home				ADDRESS Upper Marlboro, Md.		24a. REC'D BY REGISTRAR AUG 11 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

2331

Name of Deceased [Illegible]		Date of Death [Illegible]	
Sex [Illegible]		Age [Illegible]	
Race [Illegible]		Birth Date [Illegible]	
Place of Birth [Illegible]		Date of Birth [Illegible]	
Usual Residence [Illegible]		Date of Death [Illegible]	
Cause of Death [Illegible]		Date of Death [Illegible]	
Place of Death [Illegible]		Date of Death [Illegible]	
Signature of Physician [Illegible]		Signature of Registrar [Illegible]	
Date of Signature [Illegible]		Date of Signature [Illegible]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08274

8274

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale			c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berwyn Heights		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital				d. STREET ADDRESS 8908 58th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mabel Middle Vera Last Mullican				4. DATE OF DEATH Month July Day 6 Year 19 59			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-3-88	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N. Carolina	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Lee C. Mullice				14. MOTHER'S MAIDEN NAME Mary Hartman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address John W. Mullican; Box 133, Bowie, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442x DUE TO Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Muloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Muloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> July 6, 1959			
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF July 9, 1959		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville Md.		24a. REC'D BY REGISTRAR DATE JUL 10 '59	
				24b. REGISTRAR'S SIGNATURE <i>Arthur L. H.</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. File pages 1 and 2 with the registrar for burial, cremation, or removal.

Name of Deceased		John A. Sullivan	
Age		35	
Sex		Male	
Race		White	
Date of Death		April 15, 1934	
Place of Death		Home, 103, Bowie, Md.	
Cause of Death		Pneumonia	
Manner of Death		Natural	
Signature of Medical Examiner		J. C. Sullivan	
Signature of Coroner		John A. Sullivan	
Signature of Registrar		John A. Sullivan	
Signature of Physician		John A. Sullivan	
Signature of Nurse		John A. Sullivan	
Signature of Undertaker		John A. Sullivan	
Signature of Burial		John A. Sullivan	
Signature of Cremation		John A. Sullivan	
Signature of Other		John A. Sullivan	

GOVERNMENT PRINTING OFFICE

8275

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 34 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. STREET ADDRESS 4302 Emerson Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bernard Middle G Last Myles				4. DATE OF DEATH Month July Day 29 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 24 Jan 1900	
9. AGE (In years last birthday) yrs. 59		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building	
11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME George Myles		14. MOTHER'S MAIDEN NAME Lucy Ramey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mae G. Myles, Wife		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarction Small Bowel & Asc. Colon 454X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombosis, Aorta (c) Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 18 hrs. 2 yrs. 15 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from 6/25, 1959 to 7/29, 1959 , that I last saw the deceased alive on 7/28, 1959 , and that death occurred at 2:00 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Wm. J. Holbrook M.D.				ADDRESS (Street, city or town, state) 4500 College Ave., College Park, Md.			
DATE SIGNED 2/29/59							
PHYSICIAN'S NAME (Type) Dr. William Holbrook., M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/31/59		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Halley's Funeral Home				ADDRESS Mr. Rainier		24a. REC'D BY REGISTRAR DATE AUG 3 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Howard			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. After this certificate has been signed by the attending physician and completed, it should be filed with the FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10

<p>1. Name of deceased: <i>John Doe</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Date of birth: <i>Jan 1, 1900</i></p>		<p>4. Age: <i>25</i></p>	
<p>5. Place of birth: <i>John Doe</i></p>		<p>6. Date of death: <i>Jan 1, 1925</i></p>	
<p>7. Cause of death: <i>Heart Disease</i></p>		<p>8. Place of death: <i>John Doe</i></p>	
<p>9. Signature of physician: <i>John Doe</i></p>		<p>10. Signature of registrar: <i>John Doe</i></p>	
<p>11. Signature of witness: <i>John Doe</i></p>		<p>12. Signature of witness: <i>John Doe</i></p>	
<p>13. Signature of witness: <i>John Doe</i></p>		<p>14. Signature of witness: <i>John Doe</i></p>	
<p>15. Signature of witness: <i>John Doe</i></p>		<p>16. Signature of witness: <i>John Doe</i></p>	
<p>17. Signature of witness: <i>John Doe</i></p>		<p>18. Signature of witness: <i>John Doe</i></p>	
<p>19. Signature of witness: <i>John Doe</i></p>		<p>20. Signature of witness: <i>John Doe</i></p>	
<p>21. Signature of witness: <i>John Doe</i></p>		<p>22. Signature of witness: <i>John Doe</i></p>	
<p>23. Signature of witness: <i>John Doe</i></p>		<p>24. Signature of witness: <i>John Doe</i></p>	
<p>25. Signature of witness: <i>John Doe</i></p>		<p>26. Signature of witness: <i>John Doe</i></p>	
<p>27. Signature of witness: <i>John Doe</i></p>		<p>28. Signature of witness: <i>John Doe</i></p>	
<p>29. Signature of witness: <i>John Doe</i></p>		<p>30. Signature of witness: <i>John Doe</i></p>	
<p>31. Signature of witness: <i>John Doe</i></p>		<p>32. Signature of witness: <i>John Doe</i></p>	
<p>33. Signature of witness: <i>John Doe</i></p>		<p>34. Signature of witness: <i>John Doe</i></p>	
<p>35. Signature of witness: <i>John Doe</i></p>		<p>36. Signature of witness: <i>John Doe</i></p>	
<p>37. Signature of witness: <i>John Doe</i></p>		<p>38. Signature of witness: <i>John Doe</i></p>	
<p>39. Signature of witness: <i>John Doe</i></p>		<p>40. Signature of witness: <i>John Doe</i></p>	
<p>41. Signature of witness: <i>John Doe</i></p>		<p>42. Signature of witness: <i>John Doe</i></p>	
<p>43. Signature of witness: <i>John Doe</i></p>		<p>44. Signature of witness: <i>John Doe</i></p>	
<p>45. Signature of witness: <i>John Doe</i></p>		<p>46. Signature of witness: <i>John Doe</i></p>	
<p>47. Signature of witness: <i>John Doe</i></p>		<p>48. Signature of witness: <i>John Doe</i></p>	
<p>49. Signature of witness: <i>John Doe</i></p>		<p>50. Signature of witness: <i>John Doe</i></p>	
<p>51. Signature of witness: <i>John Doe</i></p>		<p>52. Signature of witness: <i>John Doe</i></p>	
<p>53. Signature of witness: <i>John Doe</i></p>		<p>54. Signature of witness: <i>John Doe</i></p>	
<p>55. Signature of witness: <i>John Doe</i></p>		<p>56. Signature of witness: <i>John Doe</i></p>	
<p>57. Signature of witness: <i>John Doe</i></p>		<p>58. Signature of witness: <i>John Doe</i></p>	
<p>59. Signature of witness: <i>John Doe</i></p>		<p>60. Signature of witness: <i>John Doe</i></p>	
<p>61. Signature of witness: <i>John Doe</i></p>		<p>62. Signature of witness: <i>John Doe</i></p>	
<p>63. Signature of witness: <i>John Doe</i></p>		<p>64. Signature of witness: <i>John Doe</i></p>	
<p>65. Signature of witness: <i>John Doe</i></p>		<p>66. Signature of witness: <i>John Doe</i></p>	
<p>67. Signature of witness: <i>John Doe</i></p>		<p>68. Signature of witness: <i>John Doe</i></p>	
<p>69. Signature of witness: <i>John Doe</i></p>		<p>70. Signature of witness: <i>John Doe</i></p>	
<p>71. Signature of witness: <i>John Doe</i></p>		<p>72. Signature of witness: <i>John Doe</i></p>	
<p>73. Signature of witness: <i>John Doe</i></p>		<p>74. Signature of witness: <i>John Doe</i></p>	
<p>75. Signature of witness: <i>John Doe</i></p>		<p>76. Signature of witness: <i>John Doe</i></p>	
<p>77. Signature of witness: <i>John Doe</i></p>		<p>78. Signature of witness: <i>John Doe</i></p>	
<p>79. Signature of witness: <i>John Doe</i></p>		<p>80. Signature of witness: <i>John Doe</i></p>	
<p>81. Signature of witness: <i>John Doe</i></p>		<p>82. Signature of witness: <i>John Doe</i></p>	
<p>83. Signature of witness: <i>John Doe</i></p>		<p>84. Signature of witness: <i>John Doe</i></p>	
<p>85. Signature of witness: <i>John Doe</i></p>		<p>86. Signature of witness: <i>John Doe</i></p>	
<p>87. Signature of witness: <i>John Doe</i></p>		<p>88. Signature of witness: <i>John Doe</i></p>	
<p>89. Signature of witness: <i>John Doe</i></p>		<p>90. Signature of witness: <i>John Doe</i></p>	
<p>91. Signature of witness: <i>John Doe</i></p>		<p>92. Signature of witness: <i>John Doe</i></p>	
<p>93. Signature of witness: <i>John Doe</i></p>		<p>94. Signature of witness: <i>John Doe</i></p>	
<p>95. Signature of witness: <i>John Doe</i></p>		<p>96. Signature of witness: <i>John Doe</i></p>	
<p>97. Signature of witness: <i>John Doe</i></p>		<p>98. Signature of witness: <i>John Doe</i></p>	
<p>99. Signature of witness: <i>John Doe</i></p>		<p>100. Signature of witness: <i>John Doe</i></p>	

8332

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>PR. George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BRANDYWINE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine, md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route 2-Box</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>L.</u> Last <u>NAIR</u>		4. DATE OF DEATH Month <u>July</u> Day <u>28</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 13-1902</u>
9. AGE (In years lost birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Walter P. Nair</u>		14. MOTHER'S MAIDEN NAME <u>Clara West</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>578-01-2353</u>	
17. INFORMANT <u>Hazel W. Nair</u> Address <u>Brandywine md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Diabetes Mellitus</u> DUE TO (c) <u>Angina Pectoris</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u>59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-12</u> , 19 <u>59</u> , to <u>7-27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7-28</u> , 19 <u>59</u> , and that death occurred at <u>4:47</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard W. D. Dean</u> M.D.		DATE SIGNED <u>Brandywine, md</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 31-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Southland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Domino Bros. Funeral Home</u> ADDRESS <u>1661 Good Hope Rd SE WASH DC</u>		24a. RECEIVED BY REGISTRAR DATE <u>JUL 31 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 only should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

100-330

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

CENTRAL BUREAU OF DEATHS

333

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8270 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08277

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Warrens Hospital				d. STREET ADDRESS 14 Betty Lane			
3. NAME OF DECEASED (Type or print) First Alexander Middle Nicol Last				4. DATE OF DEATH Month July Day 9 Year 19 59			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-21-08	9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) State Roads Inspector		10b. KIND OF BUSINESS OR INDUSTRY Highways		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Nicol				14. MOTHER'S MAIDEN NAME Mary Hausman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.#2 213-09-6432		17. INFORMANT Address Carl Cesnick; 2704 Angle St., Erie, Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c) stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		July 9, 1959	
22a. REMOVAL OF CREMATION, Burial		22b. DATE THEREOF 7/13/59		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Eichhorn Funeral Home				ADDRESS Lonaconing, Md.		24a. REC'D BY REGISTRAR DATE JUL 13 '59	
				24b. REGISTRAR'S SIGNATURE Orlwin S. Kraus			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for burial, cremation, or removal.

Figure 1

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 8333 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08278

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>			c. LENGTH OF STAY IN 1b <u>Transient</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Letcher Road</u>				d. STREET ADDRESS <u>Route # 1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frances Joseph Nimmerichter</u>				4. DATE OF DEATH Month Day Year <u>July 25 19 59</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 5, 1904</u>		9. AGE (In years last birthday) <u>55</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Service Station Austria</u>			11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Anton Nimmerichter</u>				14. MOTHER'S MAIDEN NAME <u>Anna Barilitz</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-05-8183</u>		17. INFORMANT Address <u>Mrs Lena Nimmerichter same as # 2</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> <u>442X</u> DUE TO Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>James I. Boyd</u>				DATE SIGNED <u>July 26, 1959</u>					
EXAMINER'S NAME (Type) <u>James I. Boyd</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-29-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Peters</u>		22d. LOCATION (City, town, or county) (State) <u>Waldorf, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Thront Funeral Home, Waldorf, Md.</u>				24a. REC'D BY REGISTRAR <u>JUL 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

3833 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

FILE NO.

DATE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY INTO STATE

PLACE OF ENTRY INTO STATE

DATE OF DEPARTURE FROM STATE

PLACE OF DEPARTURE FROM STATE

DATE OF RETURN TO STATE

PLACE OF RETURN TO STATE

DATE OF DEATH

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8229

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>5701-39th Avenue</i>		d. STREET ADDRESS <i>5701-39th Avenue</i>	
3. NAME OF DECEASED (Type or print) First <i>HENRY</i> Middle <i>ADOLPH</i> Last <i>NYLIN</i>		4. DATE OF DEATH Month <i>7</i> - Day <i>1</i> - Year <i>1959</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/19, 1894</i>
9. AGE (In years last day) <i>64</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Proof reader</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Government</i>	
11. BIRTHPLACE (State or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Peter Nylin</i>		14. MOTHER'S MAIDEN NAME <i>Augusta Johnson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or branch of service) <i>yes</i>		16. SOCIAL SECURITY NO. <i>111-11-1419</i>	
17. INFORMANT <i>Viola S. Nylin, wife</i>		Address <i>above</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Occlusion</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Coronary arteriosclerosis</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>15+ MIN.</i> <i>4 YRS I</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Coronary arteriosclerosis</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>6/10</i> , 19 <i>57</i> , to <i>7-1</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>7/1</i> , 19 <i>59</i> , and that death occurred at <i>11 P.</i> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>R. C. Kirchner</i> M.D.		ADDRESS (Street, city or town, state) <i>16480-N. H. Ave</i>	
PHYSICIAN'S NAME (Type) <i>R. C. KIRCHNER</i>		DATE SIGNED <i>7-1-59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>7/6/59</i>		22b. DATE THEREOF <i>7/6/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Arlington National</i>		22d. LOCATION (City, town, or county) (State) <i>Arlington Va.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Waller's Funeral Home, Inc.</i>		ADDRESS <i>Mt. Rainier, Md.</i>	
24a. REC'D BY REGISTRAR <i>JUL 6 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Charles S. Hume</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. The funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1933

DATE OF DEATH

Name of Deceased		Sex		Age		Race		Color		Religion		Marital Status		Occupation		Place of Birth		Date of Birth		Date of Death		Time of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Nurse		Signature of Undertaker		Signature of Burial		Signature of Cremation		Signature of Other	
John Doe		Male		45		White		Caucasian		Roman Catholic		Married		Farmer		Maryland		Jan 1, 1933		Jan 1, 1933		10:00 AM		Home		Heart Disease		Natural		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe			

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete certificate filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

8277

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08280

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 23 Greenbelt	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8-A Southway Road		d. STREET ADDRESS 8-A Southway Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARION Middle ORE Last ORE		4. DATE OF DEATH Month July Day 12th , Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 12th, 1886
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home	
11. BIRTHPLACE (State or foreign country) Philadelphia, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John M. Price		14. MOTHER'S MAIDEN NAME Catherine Preston	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Mrs. Edward Kaighn, 8-A Southway, Greenbelt, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myelogenous Leukemia 2041 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 30, 1958 , to July 12, 1959 , that I last saw the deceased alive on July 11, 1959 , and that death occurred at 9:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 30-C Ridge Road, Greenbelt, Md. DATE SIGNED 7/13/1959			
ACTUAL SIGNATURE Hans Wodak M.D.			
PHYSICIAN'S NAME (Type) Hans Wodak			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 7/13/59	
22c. NAME OF CEMETERY OR CREMATORY —		22d. LOCATION (City, town, or county) (State) Millville, N.J.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		24a. REC'D BY REGISTRAR DATE JUL 14 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8278 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08281

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 9715 52nd Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Lillye May Payne				4. DATE OF DEATH Month July Day 4 Year 19 59					
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-29-73		9. AGE (In years last birthday) 86 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Franklin Knight				14. MOTHER'S MAIDEN NAME Sarah Matthews					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 		17. INFORMANT Robert P. Payne, Same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Comminuted fracture of femur with bone nailing operation. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall in home.					
20c. TIME OF INJURY Hour 7:30 AM 6-22-59 19		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) College Park		(County) Pr. Geo.	
20g. (State) Md.									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John T. Maloney</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7-8-59		22c. NAME OF CEMETERY OR CREMATORY Parkwood Cem.		22d. LOCATION (City, town, or county) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck				ADDRESS 5305 Harford Rd.		24a. REC'D BY REGISTRAR JUL 7 59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knead</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar. To burial, cremation, or removal.

2278 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

Name of Deceased <i>John Doe</i>		Sex <i>Male</i>		Age <i>45</i>	
Date of Death <i>1-10-1918</i>		Place of Death <i>Home</i>		Cause of Death <i>Heart Disease</i>	
Occupation <i>Teacher</i>		Residence <i>123 Main St.</i>		Manner of Death <i>Natural</i>	
Signature of Medical Examiner <i>J. H. Smith</i>		Signature of Coroner <i>W. B. Jones</i>		Signature of Registrar <i>M. A. Brown</i>	
Date of Certificate <i>1-10-1918</i>		Place of Issuance <i>Baltimore</i>		Official Seal <i>Seal of the State Department of Health</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8279 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08282

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 16		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier		d. STREET ADDRESS 4400 - 29th Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Vincent Middle S. Last Peck				4. DATE OF DEATH Month 7 Day 21 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-22-1895	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months 11 Days 30		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) power plant operator				10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Sylvester C. Peck				14. MOTHER'S MAIDEN NAME Catherine Walsh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none		16. SOCIAL SECURITY NO. none		17. INFORMANT Edna K. Peck		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 433.0 DUE TO Empyema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carbolic acid complicating surgery. DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John D. Maloney				DATE SIGNED 7-23-59			
EXAMINER'S NAME (Type) JOHN T. MALONEY				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 7-24-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Malley's Funeral Home				ADDRESS Mt. Rainier, Md.		24a. REC'D BY REGISTRAR JUL 27 '59	
24b. REGISTRAR'S SIGNATURE William L. Kraus							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 must be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF TEXAS
COUNTY OF DALLAS

227

MAXIMUM WEIGHT OF HEAVY-BUILDING 25
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: John Doe
AGE: 45 SEX: M
DATE OF DEATH: 10-15-1968
PLACE OF DEATH: Home
CAUSE OF DEATH: Heart Disease
MANNER OF DEATH: Natural
SIGNATURE OF EXAMINER: [Signature]
DATE: 10-15-1968
OFFICE: Dallas

8280

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 3 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 7107 Glenridge e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Lillian J Perkinson				4. DATE OF DEATH Month July Day 10 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 27 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Paul Moore				14. MOTHER'S MAIDEN NAME Mary Peasley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Address Thomas Edward Perkinson Hyattsville Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.1 DUE TO acute Paul Edmund Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary heart failure DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 59 , to July 10 , 19 59 , that I last saw the deceased alive on July 10 , 19 59 , and that death occurred at 12:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE William B Hagan M.D.				ADDRESS (Street, city or town, state) University Park, Md DATE SIGNED July 12/59			
PHYSICIAN'S NAME (Type) William B Hagan				LOCATION (City, town, or county) (State) University Park, Md.			
22a. BURIAL, CREMATION, REBURY (Specify) Burial		22b. DATE THEREOF 7/13/59		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch s sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE JUL 14 '59	
						24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. Pending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2538

Page 1 of 1

NAME OF DECEASED

AGE

RESIDENCE

DATE OF DEATH

CAUSE OF DEATH

SEX

EDUCATION

DATE OF BIRTH

PLACE OF BIRTH

RELIGION

PROFESSION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

TIME OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

SEX

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

8281

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Boy Pinkney		4. DATE OF DEATH July 10 19 59	
5. SEX Male	6. COLOR OR RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 July 1959
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) yrs. 11 11 59	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Gonza Bernard Pinkney		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME Susie Elizabeth Stewart	
16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 760.0 intracranial hemorrhage (with known multiple potential) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 760.0 intracranial hemorrhage (with known multiple potential) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10 July , 19 59 , to 10 July , 19 59 , that I lost saw the deceased alive on 10 July , 19 59 , and that death occurred at 5,50P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Thomas A. Christensen M.D.			
PHYSICIAN'S NAME (Type) Dr. Thomas Christensen M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF July 25 1959	
22c. NAME OF CEMETERY OR CREMATORY Prince George Gen. Hospital Chesverly, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr. Administrator		24a. REC'D BY REGISTRAR JUL 30 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2077345XV5

10-5-54

MASSACHUSETTS DEPARTMENT OF HEALTH - BATHING

CERTIFICATE OF DEATH

RECEIVED
BUREAU OF VITAL RECORDS
JUL 13 1954

Name of Deceased		Date of Birth	
Sex		Race	
Marital Status		Place of Birth	
Usual Residence		Date of Death	
Cause of Death		Place of Death	
Physician's Signature		Date of Certificate	
Registrar's Signature		Date of Registration	
Municipal Health Officer's Signature		Date of Filing	
County Health Officer's Signature		Date of Filing	
State Registrar's Signature		Date of Filing	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8334

CERTIFICATE OF DEATH

18285

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OAKCREST, LAUREL, LIFE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OAKCREST, LAUREL R.F.D.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LOCUST ST</u>		d. STREET ADDRESS <u>1 LOCUST</u>	
3. NAME OF DECEASED (Type or print) <u>ESTELLE</u> First Middle Last		4. DATE OF DEATH <u>July 25</u> 19 <u>59</u> Month Day Year	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 16 1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>DANNY THOMAS</u>		14. MOTHER'S MAIDEN NAME <u>JENNY WILLIAMS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mamie Powell Laurel R.F.D.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Gen'l Arteriosclerosis</u> DUE TO (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>10 yrs</u> <u>16 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/17</u> , 19 <u>57</u> , to <u>7/25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7/23</u> , 19 <u>59</u> , and that death occurred at <u>6 A</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <u>7/27/59</u>	
ACTUAL SIGNATURE <u>J M Warren M.D.</u>		PHYSICIAN'S NAME (Type) <u>Laurel R.F.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>July 28/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BECKON'S CHAPEL</u>	22d. LOCATION (City, town, or county) (State) <u>LAUREL MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ridgely S. Bell</u> ADDRESS <u>1200 Knappa Place</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 28 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Francis</u>

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8282

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Proctor Last Proctor		4. DATE OF DEATH Month July Day 30 Year 1959	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 3, 1869
9. AGE (In years lost birthday) 90 yrs.		10. IF UNDER 1 YEAR Months 40 Days 10 Hours 40 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Norman Proctor		14. MOTHER'S MAIDEN NAME Brandywine	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 4814-7151	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA due to Arteriosclerosis DUE TO Shock Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hemorrhage DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 40 hrs 40 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____ and that death occurred at 2:45P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas G. Maloney M.D.		DATE SIGNED 4814-7151	
PHYSICIAN'S NAME (Type) Dr. Thomas Maloney			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-1-59	
22c. NAME OF CEMETERY OR CREMATORY St. Peter's		22d. LOCATION (City, town, or county) (State) Charles Co Md	
23. FUNERAL DIRECTOR'S SIGNATURE George H. Nelson		24a. REC'D BY REGISTRAR AUG 3 '59	
24b. REGISTRAR'S SIGNATURE Charles H. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

10050

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES

CERTIFICATE OF DEATH

1982

NAME OF DECEASED: [illegible] SEX: [illegible] AGE: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

ICD-9 CODE: [illegible]

DATE OF BIRTH: [illegible] PLACE OF BIRTH: [illegible]

EDUCATION: [illegible]

DATE OF MARRIAGE: [illegible] PLACE OF MARRIAGE: [illegible]

DATE OF DEPARTURE: [illegible] PLACE OF DEPARTURE: [illegible]

DATE OF RETURN: [illegible] PLACE OF RETURN: [illegible]

DATE OF ARRIVAL: [illegible] PLACE OF ARRIVAL: [illegible]

DATE OF DEPARTURE: [illegible] PLACE OF DEPARTURE: [illegible]

DATE OF RETURN: [illegible] PLACE OF RETURN: [illegible]

DATE OF ARRIVAL: [illegible] PLACE OF ARRIVAL: [illegible]

DATE OF DEPARTURE: [illegible] PLACE OF DEPARTURE: [illegible]

DATE OF RETURN: [illegible] PLACE OF RETURN: [illegible]

DATE OF ARRIVAL: [illegible] PLACE OF ARRIVAL: [illegible]

DATE OF DEPARTURE: [illegible] PLACE OF DEPARTURE: [illegible]

DATE OF RETURN: [illegible] PLACE OF RETURN: [illegible]

DATE OF ARRIVAL: [illegible] PLACE OF ARRIVAL: [illegible]

DATE OF DEPARTURE: [illegible] PLACE OF DEPARTURE: [illegible]

DATE OF RETURN: [illegible] PLACE OF RETURN: [illegible]

10050

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES

10050

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8283

CERTIFICATE OF DEATH

08287

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 15 hrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Roy				4. DATE OF DEATH Month July Day 25 Year 19 59			
5. SEX Male		6. COLOR OR RACE Black		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 31 Mar. 1909	
9. AGE (In years lost birthday) 50 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Josiah Proctor				14. MOTHER'S MAIDEN NAME Ida Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.			
17. INFORMANT Louise Proctor				Address Route 3, Clinton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal hemorrhage, massive 540.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Gastric ulcer DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 1 day
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 24 , 19 59 , to July 25 , 19 59 , that I last saw the deceased alive on July 25 , 19 59 , and that death occurred at 3,35 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE James R. Goodson				ADDRESS (Street, city or town, state) 1746 K St. N.W.			
PHYSICIAN'S NAME (Type) James R. Goodson, M.D.				DATE SIGNED Washington 6 D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-28-59		22c. NAME OF CEMETERY OR CREMATORY St. John		22d. LOCATION (City, town, or county) (State) Clinton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Collins				ADDRESS 4339 Hunt Rd		24a. REC'D BY REGISTRAR JUL 28 59	
						24b. REGISTRAR'S SIGNATURE Carroll S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10

0 4 2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08288

8284 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Large Cherry		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Large (27)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General (D.O.A.)			d. STREET ADDRESS 7802-Large Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) FRANK A QUEEN			4. DATE OF DEATH Month July Day 6 Year 1959		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 24, 1912		9. AGE (In years last birthday) 47 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Ma ryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Queen			14. MOTHER'S MAIDEN NAME Alice Savoy		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Ida Queen 7802-Large Rd. Large Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Acute congestive heart failure Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) JOHN T. MALONEY, MD			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) 7-10-59		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Holy Family	
22d. LOCATION (City, town, or county) Woodmore Md		22e. (State)		22f. (City or town)	
23. FUNERAL DIRECTOR'S SIGNATURE H.S. Washington & Sons 467-N-St. N.W. D.C.			24. RECEIVED BY REGISTRAR JUL 18 59		24b. REGISTRAR'S SIGNATURE Robert S. Thoma

MEDICAL CERTIFICATION

2

HEALTH DEPT.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE	

8285

CERTIFICATE OF DEATH

Reg. Dist. No.

MEDICAL CERTIFICATION

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

8542

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of birth: <u>Jan 15, 1900</u></p>	
<p>5. Place of birth: <u>John Doe</u></p>		<p>6. Date of death: <u>Jan 15, 1945</u></p>	
<p>7. Cause of death: <u>Heart disease</u></p>		<p>8. Place of death: <u>John Doe</u></p>	
<p>9. Signature of physician: <u>John Doe</u></p>		<p>10. Signature of registrar: <u>John Doe</u></p>	
<p>11. Date of registration: <u>Jan 15, 1945</u></p>		<p>12. Place of registration: <u>John Doe</u></p>	
<p>13. Signature of registrar: <u>John Doe</u></p>		<p>14. Signature of registrar: <u>John Doe</u></p>	
<p>15. Signature of registrar: <u>John Doe</u></p>		<p>16. Signature of registrar: <u>John Doe</u></p>	
<p>17. Signature of registrar: <u>John Doe</u></p>		<p>18. Signature of registrar: <u>John Doe</u></p>	
<p>19. Signature of registrar: <u>John Doe</u></p>		<p>20. Signature of registrar: <u>John Doe</u></p>	
<p>21. Signature of registrar: <u>John Doe</u></p>		<p>22. Signature of registrar: <u>John Doe</u></p>	
<p>23. Signature of registrar: <u>John Doe</u></p>		<p>24. Signature of registrar: <u>John Doe</u></p>	
<p>25. Signature of registrar: <u>John Doe</u></p>		<p>26. Signature of registrar: <u>John Doe</u></p>	
<p>27. Signature of registrar: <u>John Doe</u></p>		<p>28. Signature of registrar: <u>John Doe</u></p>	
<p>29. Signature of registrar: <u>John Doe</u></p>		<p>30. Signature of registrar: <u>John Doe</u></p>	
<p>31. Signature of registrar: <u>John Doe</u></p>		<p>32. Signature of registrar: <u>John Doe</u></p>	
<p>33. Signature of registrar: <u>John Doe</u></p>		<p>34. Signature of registrar: <u>John Doe</u></p>	
<p>35. Signature of registrar: <u>John Doe</u></p>		<p>36. Signature of registrar: <u>John Doe</u></p>	
<p>37. Signature of registrar: <u>John Doe</u></p>		<p>38. Signature of registrar: <u>John Doe</u></p>	
<p>39. Signature of registrar: <u>John Doe</u></p>		<p>40. Signature of registrar: <u>John Doe</u></p>	
<p>41. Signature of registrar: <u>John Doe</u></p>		<p>42. Signature of registrar: <u>John Doe</u></p>	
<p>43. Signature of registrar: <u>John Doe</u></p>		<p>44. Signature of registrar: <u>John Doe</u></p>	
<p>45. Signature of registrar: <u>John Doe</u></p>		<p>46. Signature of registrar: <u>John Doe</u></p>	
<p>47. Signature of registrar: <u>John Doe</u></p>		<p>48. Signature of registrar: <u>John Doe</u></p>	
<p>49. Signature of registrar: <u>John Doe</u></p>		<p>50. Signature of registrar: <u>John Doe</u></p>	
<p>51. Signature of registrar: <u>John Doe</u></p>		<p>52. Signature of registrar: <u>John Doe</u></p>	
<p>53. Signature of registrar: <u>John Doe</u></p>		<p>54. Signature of registrar: <u>John Doe</u></p>	
<p>55. Signature of registrar: <u>John Doe</u></p>		<p>56. Signature of registrar: <u>John Doe</u></p>	
<p>57. Signature of registrar: <u>John Doe</u></p>		<p>58. Signature of registrar: <u>John Doe</u></p>	
<p>59. Signature of registrar: <u>John Doe</u></p>		<p>60. Signature of registrar: <u>John Doe</u></p>	
<p>61. Signature of registrar: <u>John Doe</u></p>		<p>62. Signature of registrar: <u>John Doe</u></p>	
<p>63. Signature of registrar: <u>John Doe</u></p>		<p>64. Signature of registrar: <u>John Doe</u></p>	
<p>65. Signature of registrar: <u>John Doe</u></p>		<p>66. Signature of registrar: <u>John Doe</u></p>	
<p>67. Signature of registrar: <u>John Doe</u></p>		<p>68. Signature of registrar: <u>John Doe</u></p>	
<p>69. Signature of registrar: <u>John Doe</u></p>		<p>70. Signature of registrar: <u>John Doe</u></p>	
<p>71. Signature of registrar: <u>John Doe</u></p>		<p>72. Signature of registrar: <u>John Doe</u></p>	
<p>73. Signature of registrar: <u>John Doe</u></p>		<p>74. Signature of registrar: <u>John Doe</u></p>	
<p>75. Signature of registrar: <u>John Doe</u></p>		<p>76. Signature of registrar: <u>John Doe</u></p>	
<p>77. Signature of registrar: <u>John Doe</u></p>		<p>78. Signature of registrar: <u>John Doe</u></p>	
<p>79. Signature of registrar: <u>John Doe</u></p>		<p>80. Signature of registrar: <u>John Doe</u></p>	
<p>81. Signature of registrar: <u>John Doe</u></p>		<p>82. Signature of registrar: <u>John Doe</u></p>	
<p>83. Signature of registrar: <u>John Doe</u></p>		<p>84. Signature of registrar: <u>John Doe</u></p>	
<p>85. Signature of registrar: <u>John Doe</u></p>		<p>86. Signature of registrar: <u>John Doe</u></p>	
<p>87. Signature of registrar: <u>John Doe</u></p>		<p>88. Signature of registrar: <u>John Doe</u></p>	
<p>89. Signature of registrar: <u>John Doe</u></p>		<p>90. Signature of registrar: <u>John Doe</u></p>	
<p>91. Signature of registrar: <u>John Doe</u></p>		<p>92. Signature of registrar: <u>John Doe</u></p>	
<p>93. Signature of registrar: <u>John Doe</u></p>		<p>94. Signature of registrar: <u>John Doe</u></p>	
<p>95. Signature of registrar: <u>John Doe</u></p>		<p>96. Signature of registrar: <u>John Doe</u></p>	
<p>97. Signature of registrar: <u>John Doe</u></p>		<p>98. Signature of registrar: <u>John Doe</u></p>	
<p>99. Signature of registrar: <u>John Doe</u></p>		<p>100. Signature of registrar: <u>John Doe</u></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete certificate has been signed by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8230 CERTIFICATE OF DEATH

08290

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 1yr 5 mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Manor-4922 LaSalle Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John F. Quinn		4. DATE OF DEATH Month July Day 10 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/4/77
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Monotype Machinest		10b. KIND OF BUSINESS OR INDUSTRY U.S.CivilService	
11. BIRTHPLACE (State or foreign country) Rhode Island		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael Quinn		14. MOTHER'S MAIDEN NAME Margaret Bowen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Sr.M. Bernardette Joseph Hyattsville, Md.		Address 4922 LaSalle Rd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Arteriosclerotic Heart Disease DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3 weeks 6 months 5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/18/1959 , 19____, to 7/10/1959 , 19____, that I last saw the deceased alive on 7/10/1959 , 19____, and that death occurred at 1:47A M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 322- H. St. N.E. DATE SIGNED July 10/59	
ACTUAL SIGNATURE Thomas F. Collins M.D.		WASHINGTON 2, D.C.	
PHYSICIAN'S NAME (Type) Thomas F. Collins, M.D.		Washington 2, D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-14-59	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Washington, DC	
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins		24a. REC'D BY REGISTRAR DATE JUL 14 '59	
ADDRESS 3821-14th St. N.W. Wash. DC		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

CERTIFICATE OF DEATH

Name of Deceased John Quinn		Date of Birth July 19, 1888	
Sex Male		Race White	
Usual Residence 1215 Chestnut St.		Date of Death July 19, 1959	
Cause of Death Arteriosclerotic heart disease		Date of Death July 19, 1959	
Contributing Cause Coronary artery disease		Date of Death July 19, 1959	
Place of Death Home		Date of Death July 19, 1959	
Signature of Physician Dr. J. H. Quinn		Signature of Registrar John Quinn	
Date of Signature July 19, 1959		Date of Signature July 19, 1959	

8231 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY None	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Home 5805 Queens Chapel Road		d. STREET ADDRESS 18 Rhode Island Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Gertrude Middle Theresa Last Risk		4. DATE OF DEATH Month July Day 16 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 4, 1869
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months 2 Days 12 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (State or foreign country) E. Machias		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Fairfield Huntley		14. MOTHER'S MAIDEN NAME Sarah Bogue	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Sacred Heart Home, Hyattsville, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio Cerebro (c) Nephro Sclerosis DUE TO INTERVAL BETWEEN ONSET AND DEATH 11 Mths			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 23, 19 58, to July 16, 19 59, that I last saw the deceased alive on July 16, 19 59, and that death occurred at 12:05 AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE J. Chester Brady		M.D. 35 New York Ave., N.W., Wash., D.C. 7/17/59.	
PHYSICIAN'S NAME (Type) J. Chester Brady, M.D.		35 New York Avenue, N.W., Wash., D.C. 7/17/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 20, 1959	
22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO.,		ADDRESS Riverdale, Maryland.	
24a. REC'D BY REGISTRAR DATE JUL 20 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8286

CERTIFICATE OF DEATH

Reg. Dist. No.

09448

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Geroges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Patricia Middle Ann Last Robertson		4. DATE OF DEATH Month July Day 25 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 July 1959
9. AGE (In years last birthday) yrs. 16		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William A Robertson		14. MOTHER'S MAIDEN NAME Betty Louise Barfield	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mother		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Microcephaly (cerebral agensis) 753.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Terminal Phosphorus (congestive) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 2,30AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Thomas A. Christensen M.D.			
PHYSICIAN'S NAME (Type) Thomas A Christensen, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation	22b. DATE THEREOF 8/25/59	22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital,	22d. LOCATION (City, town, or county) (State) Cheverly, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Harry W Penn, Jr Administrator.		24a. REC'D BY REGISTRAR DATE SEP 2 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Knead

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1999

Name of Deceased [Illegible]		Date of Birth [Illegible]	
Sex [Illegible]		Race [Illegible]	
Usual Residence [Illegible]		Date of Death [Illegible]	
Cause of Death [Illegible]		Place of Death [Illegible]	
Physician's Signature [Illegible]		Registrar's Signature [Illegible]	
Date of Declaration [Illegible]		Date of Registration [Illegible]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8287

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08292

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
c. LENGTH OF STAY IN 1b 7 hours		d. STREET ADDRESS 4707 7th Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Emma Robinson		4. DATE OF DEATH July 4 1959	
5. SEX Female	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 50 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse		10b. KIND OF BUSINESS OR INDUSTRY N.I.H.	
11. BIRTHPLACE (State or foreign country) N. Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Will Solice		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Margaret Bumbray; 1039 Evarts St. N.E. D.C.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO 816X Conditions, if any, which gave rise to immediate cause (b) Crushed chest, fractured pelvis and cerebral contusion. (c) contusion. DUE TO 816X DUE TO contusion. DUE TO contusion.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) While riding as a passenger in an automobile, the car was struck in the rear.			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While riding as a passenger in an automobile, the car was struck in the rear.	
20c. TIME OF INJURY Month, Day, Year 2:00 P. m. 7-4- 19 59		20d. INJURY OCCURRED Highway	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Chillum Adelphi. Pr. Geo. Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John T. Maloney		DATE SIGNED July 5, 1959	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 11, 1959	22c. NAME OF CEMETERY OR CREMATORY Carver Memorial Park	22d. LOCATION (City, town, or county) (State) Laurel, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Co. 3015 12th St., N. E.		24a. REC'D BY REGISTRAR JUL 10 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Rhines			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. To burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete certificate has been signed by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08293

8288

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland c. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 mo 9 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		d. STREET ADDRESS Box 246	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Benjamin Middle Harrison Last Russell		4. DATE OF DEATH Month July Day 9 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/4/90
9. AGE (In years last birthday) yrs. 69		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Cab Driver		10b. KIND OF BUSINESS OR INDUSTRY Diamond Co.	
11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Dudley B Russell		14. MOTHER'S MAIDEN NAME Lyda Deavers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Elsie M Russell		Address Bowie, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHO PNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Thrombosis DUE TO (c) Cerebral Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 7 days 1 mos. 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CORONARY THROMBOSIS		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/31 , 19 59 , to 7/10 , 19 59 , that I last saw the deceased alive on 7/10 , 19 59 , and that death occurred at 12:58 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Norman Donat Comeau M.D.		ADDRESS (Street, city or town, state) 3503 Perry St	
DATE SIGNED 7/10/59			
PHYSICIAN'S NAME (Type) NORMAN DONAT COMEAU		MT Prince Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/13/59	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch S Sons		ADDRESS Hyattsville Md.	
24a. REC'D BY REGISTRAR DATE JUL 13 '59		24b. REGISTRAR'S SIGNATURE Colman L. Kline	

CERTIFICATE OF DEATH

2007

File No.

County

City

Age

Sex

Marital Status

Occupation

Education

Color

Religion

Place of Birth

Place of Death

Cause of Death

Time of Death

Date of Death

Time of Death

Place of Death

Place of Death

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08294

8289

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. CITY OR TOWN (If outside corporate limits, write nearest town) <u>15 Hyattsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Beland Memorial Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Adison</u> Last <u>Ryan</u>				4. DATE OF DEATH Month <u>July</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>Wh</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-23-'02</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>6</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CARL DAUBERSON</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Albin Ryan</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane Humphrey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-19-5505</u>		17. INFORMANT Address <u>Hospital Record</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>indefinite</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-5</u> , 19 <u>59</u> , to <u>7-7-59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7-7-</u> 19 <u>59</u> , and that death occurred at <u>9:00</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>D.P. Purdie</u>				ADDRESS (Street, city or town, state) <u>4404 Greensburg Rd</u>		DATE SIGNED <u>7/7/59</u>	
PHYSICIAN'S NAME (Type) <u>D.P. PURDIE</u>				<u>Riverdale, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>July 10, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN</u>		22d. LOCATION (City, town, or county) (State) <u>BLADENSBURG MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Tattum</u>				ADDRESS <u>3603 14th NW</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 10 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

CERTIFICATE OF DEATH

Reg. Dist. No.

8290

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE MARYLAND b. COUNTY PR. GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIVERDALE		c. LENGTH OF STAY IN 1b 34 YRS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4712 RAVENSWOOD RD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ERNEST RUPPERT SALMON		4. DATE OF DEATH Month Day Year JULY 22 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC 21, 1883
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEAMFITTER		10b. KIND OF BUSINESS OR INDUSTRY WASH-TERMINAL	
11. BIRTHPLACE (State or foreign country) LONDON ENGLAND		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME ALPHONSO SALMON		14. MOTHER'S MAIDEN NAME TAMLINE MOOREY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NONE		16. SOCIAL SECURITY NO. 718 14 982	
17. INFORMANT RUTH SALMON Address RIVERDALE MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSELEROTIC HEART DISEASE DUE TO (c) 2 YEARS			INTERVAL BETWEEN ONSET AND DEATH 8 HOURS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from JAN 1, 1954 to JULY 22, 1959 , that I last saw the deceased alive on JULY 22, 1959 , and that death occurred at 8 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Samuel J. N. Sugar M.D.		ADDRESS (Street, city or town, state) 4300 KAYWOOD DR. JULY 22 1959	
PHYSICIAN'S NAME (Type) SAMUEL J. N. SUGAR MD MT RAINIER MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/25/59	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln	22d. LOCATION (City, town, or county) (State) Bladesburg Md.
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Jr. ADDRESS Riverdale Md.		24a. REC'D BY REGISTRAR JUL 24 '59	24b. REGISTRAR'S SIGNATURE Arthur J. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page 2 of 2

1. NAME OF DECEASED <i>JOHN W. BROWN</i>		2. SEX <i>Male</i>	
3. DATE OF BIRTH <i>1910-01-15</i>		4. PLACE OF BIRTH <i>St. Louis, Mo.</i>	
5. OCCUPATION <i>Engineer</i>		6. CAUSE OF DEATH <i>Heart Disease</i>	
7. PLACE OF DEATH <i>Home</i>		8. TIME OF DEATH <i>10:15 AM</i>	
9. SIGNATURE OF DECEASED <i>John W. Brown</i>		10. SIGNATURE OF WITNESSES <i>John W. Brown</i>	
11. SIGNATURE OF DECEASED <i>John W. Brown</i>		12. SIGNATURE OF WITNESSES <i>John W. Brown</i>	
13. SIGNATURE OF DECEASED <i>John W. Brown</i>		14. SIGNATURE OF WITNESSES <i>John W. Brown</i>	
15. SIGNATURE OF DECEASED <i>John W. Brown</i>		16. SIGNATURE OF WITNESSES <i>John W. Brown</i>	
17. SIGNATURE OF DECEASED <i>John W. Brown</i>		18. SIGNATURE OF WITNESSES <i>John W. Brown</i>	
19. SIGNATURE OF DECEASED <i>John W. Brown</i>		20. SIGNATURE OF WITNESSES <i>John W. Brown</i>	
21. SIGNATURE OF DECEASED <i>John W. Brown</i>		22. SIGNATURE OF WITNESSES <i>John W. Brown</i>	
23. SIGNATURE OF DECEASED <i>John W. Brown</i>		24. SIGNATURE OF WITNESSES <i>John W. Brown</i>	
25. SIGNATURE OF DECEASED <i>John W. Brown</i>		26. SIGNATURE OF WITNESSES <i>John W. Brown</i>	
27. SIGNATURE OF DECEASED <i>John W. Brown</i>		28. SIGNATURE OF WITNESSES <i>John W. Brown</i>	
29. SIGNATURE OF DECEASED <i>John W. Brown</i>		30. SIGNATURE OF WITNESSES <i>John W. Brown</i>	
31. SIGNATURE OF DECEASED <i>John W. Brown</i>		32. SIGNATURE OF WITNESSES <i>John W. Brown</i>	
33. SIGNATURE OF DECEASED <i>John W. Brown</i>		34. SIGNATURE OF WITNESSES <i>John W. Brown</i>	
35. SIGNATURE OF DECEASED <i>John W. Brown</i>		36. SIGNATURE OF WITNESSES <i>John W. Brown</i>	
37. SIGNATURE OF DECEASED <i>John W. Brown</i>		38. SIGNATURE OF WITNESSES <i>John W. Brown</i>	
39. SIGNATURE OF DECEASED <i>John W. Brown</i>		40. SIGNATURE OF WITNESSES <i>John W. Brown</i>	
41. SIGNATURE OF DECEASED <i>John W. Brown</i>		42. SIGNATURE OF WITNESSES <i>John W. Brown</i>	
43. SIGNATURE OF DECEASED <i>John W. Brown</i>		44. SIGNATURE OF WITNESSES <i>John W. Brown</i>	
45. SIGNATURE OF DECEASED <i>John W. Brown</i>		46. SIGNATURE OF WITNESSES <i>John W. Brown</i>	
47. SIGNATURE OF DECEASED <i>John W. Brown</i>		48. SIGNATURE OF WITNESSES <i>John W. Brown</i>	
49. SIGNATURE OF DECEASED <i>John W. Brown</i>		50. SIGNATURE OF WITNESSES <i>John W. Brown</i>	
51. SIGNATURE OF DECEASED <i>John W. Brown</i>		52. SIGNATURE OF WITNESSES <i>John W. Brown</i>	
53. SIGNATURE OF DECEASED <i>John W. Brown</i>		54. SIGNATURE OF WITNESSES <i>John W. Brown</i>	
55. SIGNATURE OF DECEASED <i>John W. Brown</i>		56. SIGNATURE OF WITNESSES <i>John W. Brown</i>	
57. SIGNATURE OF DECEASED <i>John W. Brown</i>		58. SIGNATURE OF WITNESSES <i>John W. Brown</i>	
59. SIGNATURE OF DECEASED <i>John W. Brown</i>		60. SIGNATURE OF WITNESSES <i>John W. Brown</i>	
61. SIGNATURE OF DECEASED <i>John W. Brown</i>		62. SIGNATURE OF WITNESSES <i>John W. Brown</i>	
63. SIGNATURE OF DECEASED <i>John W. Brown</i>		64. SIGNATURE OF WITNESSES <i>John W. Brown</i>	
65. SIGNATURE OF DECEASED <i>John W. Brown</i>		66. SIGNATURE OF WITNESSES <i>John W. Brown</i>	
67. SIGNATURE OF DECEASED <i>John W. Brown</i>		68. SIGNATURE OF WITNESSES <i>John W. Brown</i>	
69. SIGNATURE OF DECEASED <i>John W. Brown</i>		70. SIGNATURE OF WITNESSES <i>John W. Brown</i>	
71. SIGNATURE OF DECEASED <i>John W. Brown</i>		72. SIGNATURE OF WITNESSES <i>John W. Brown</i>	
73. SIGNATURE OF DECEASED <i>John W. Brown</i>		74. SIGNATURE OF WITNESSES <i>John W. Brown</i>	
75. SIGNATURE OF DECEASED <i>John W. Brown</i>		76. SIGNATURE OF WITNESSES <i>John W. Brown</i>	
77. SIGNATURE OF DECEASED <i>John W. Brown</i>		78. SIGNATURE OF WITNESSES <i>John W. Brown</i>	
79. SIGNATURE OF DECEASED <i>John W. Brown</i>		80. SIGNATURE OF WITNESSES <i>John W. Brown</i>	
81. SIGNATURE OF DECEASED <i>John W. Brown</i>		82. SIGNATURE OF WITNESSES <i>John W. Brown</i>	
83. SIGNATURE OF DECEASED <i>John W. Brown</i>		84. SIGNATURE OF WITNESSES <i>John W. Brown</i>	
85. SIGNATURE OF DECEASED <i>John W. Brown</i>		86. SIGNATURE OF WITNESSES <i>John W. Brown</i>	
87. SIGNATURE OF DECEASED <i>John W. Brown</i>		88. SIGNATURE OF WITNESSES <i>John W. Brown</i>	
89. SIGNATURE OF DECEASED <i>John W. Brown</i>		90. SIGNATURE OF WITNESSES <i>John W. Brown</i>	
91. SIGNATURE OF DECEASED <i>John W. Brown</i>		92. SIGNATURE OF WITNESSES <i>John W. Brown</i>	
93. SIGNATURE OF DECEASED <i>John W. Brown</i>		94. SIGNATURE OF WITNESSES <i>John W. Brown</i>	
95. SIGNATURE OF DECEASED <i>John W. Brown</i>		96. SIGNATURE OF WITNESSES <i>John W. Brown</i>	
97. SIGNATURE OF DECEASED <i>John W. Brown</i>		98. SIGNATURE OF WITNESSES <i>John W. Brown</i>	
99. SIGNATURE OF DECEASED <i>John W. Brown</i>		100. SIGNATURE OF WITNESSES <i>John W. Brown</i>	

8291

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 41 Laurel	
d. NAME OF HOSPITAL (If not in hospital, give street address) Eugene Ireland Memorial Hosp		d. STREET ADDRESS 401 Sandy Spring Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Elmer Rudolph Schultz		4. DATE OF DEATH July 23 1959	
5. SEX male		6. COLOR OR RACE white	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-3-93	
9. AGE (In years, lost birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Rudolph B. Schultz		14. MOTHER'S MAIDEN NAME Hanna D. Welch	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-40-7459	
17. INFORMANT Mrs. E. R. Schultz		Address 401 Sandy Spring Rd Laurel Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.1 DUE TO Heart Pulmonary embolism (b) Myocardial infarction of Rt. Ventricle (c) Complication of Rt. Ventricle Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 2 hrs 6.7 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 21, 1959 to July 23, 1959, that I last saw the deceased alive on July 23, 1959, and that death occurred at 9:30 AM, from the causes and on the date stated above		ADDRESS (Street, city or town, state) DATE SIGNED July 23, 1959	
ACTUAL SIGNATURE Robert C. Wingfield		M.D. Laurel, Maryland	
PHYSICIAN'S NAME (Type) ROBERT C. WINGFIELD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial July 27, 1959		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Wildwood Cem.		22d. LOCATION (City, town, or county) (State) Williamsport Penn.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. With		ADDRESS	
24a. REC'D BY REGISTRAR DATE JUL 28 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

VS A15 (4)
15M 10/57

VS A15 (4)
15M 10/S7

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

Name of Deceased
 (last) J. C. Smith
 (first) J. C. Smith
 (middle) J. C. Smith
 Date of Death
 X

Place of Death
 Date of Death
 Cause of Death
 Signature of Physician

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8292

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08297

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale			c. LENGTH OF STAY IN 1b D.O.A.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital				d. STREET ADDRESS 5716 Chillum Heights Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Carl Postal Scott				4. DATE OF DEATH Month Day Year July 15 19 59			
5. SEX Male		6. COLOR OR RACE colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-13-29	
9. AGE (In years last birthday) 29 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Apartment		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Clifton Scott		14. MOTHER'S MAIDEN NAME Ethel Dickerson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. II W-W 266-36-9563		17. INFORMANT Thelma Wilkins; 1809 Rosedale Street, N.E. Washington, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exhaustion DUE TO 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Toxemia DUE TO (c) Bronchopneumonia							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				DATE SIGNED July 15, 1959			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 7-17-59		22c. NAME OF CEMETERY OR CREMATORY Family Cemetery		22d. LOCATION (City, town, or county) (State) Goouchland VA	
23. FUNERAL DIRECTOR'S SIGNATURE Henry Washington 467 N at NW				24a. REC'D BY REGISTRAR DATE JUL 22 '59		24b. REGISTRAR'S SIGNATURE Charles E. Kline	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
 333. MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death	
John Doe		Male		45		10-15-1900		Boston, Mass.		Boston, Mass.		Heart Disease		Natural	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Witness		Signature of Witness		Signature of Witness		Signature of Witness		Signature of Witness	
Date of Examination		Time of Examination		Place of Examination		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Witness		Signature of Witness	
10-20-1900		10:00 AM		Boston, Mass.		John Doe		John Doe		John Doe		John Doe		John Doe	

8293

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laurel (Oakrest)</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laurel (Oakrest)</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>Anna Virginia Scruggs</i>		4. DATE OF DEATH <i>July 30 1959</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 14 1908</i>
9. AGE (In years last birthday) <i>52 yrs.</i>		10. BIRTHPLACE (State or foreign country) <i>Chatham, Virginia</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Chatham, Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Jacob Sipe</i>		14. MOTHER'S MAIDEN NAME <i>Julia Vear</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Mr. Jesse Scruggs, Laurel, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart Myocardial Infarction</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Chronic Illness</i> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 30 1959</i> to <i>July 30 1959</i> , that I last saw the deceased alive on <i>July 30 1959</i> , and that death occurred at <i>3:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Robert C. Wingfield</i> M.D.		DATE SIGNED <i>July 30 1959</i>	
PHYSICIAN'S NAME (Type) <i>ROBERT C. WINGFIELD</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Aug 2, 1959</i>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <i>St. Johns Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Beltville Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>De Witt Chandler</i>		ADDRESS <i>Laurel, Md.</i>	
24a. REC'D BY REGISTRAR <i>AUG 4 59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

8223

Reg. Dist. No.

1. Name of deceased: *Josephine Elizabeth Smith*
2. Sex: *Female*
3. Age: *68*
4. Date of death: *April 15, 1954*
5. Place of death: *Home*
6. Cause of death: *Heart Disease*
7. Duration of illness: *2 weeks*
8. Name of attending physician: *Dr. J. H. Smith*
9. Name of informant: *John Smith*
10. Signature of informant: *[Signature]*

RECEIVED
BUREAU OF VITAL STATISTICS
MAY 10 1954

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 10-15-2000 BY 60322 UCBAW

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8294

Items 6, 13, 14 Film G247 8-25-59 et

CERTIFICATE OF DEATH

08299

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SARA Middle Sara Last Shorter		4. DATE OF DEATH Month July Day 8 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1897 ?
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (In years last birthday) yn. 62
11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Robert Shorter Upper Marlboro		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Acute pulmonary edema & acute pyelonephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio sclerosis of heart DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 8 59 to July 8 59 that I last saw the deceased alive on July 8 59 and that death occurred at 9 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. L. Etienne		ADDRESS (Street, city or town, state) 4713 - Kensington Rd College Park, Md	
PHYSICIAN'S NAME (Type) W. L. ETIENNE		DATE SIGNED 7-9-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) 2-13-59	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY Holy Family	22d. LOCATION (City, town, or county) (State) Wood Manor Md
23. FUNERAL DIRECTOR'S SIGNATURE P S Woodhull		ADDRESS 467 N ST NW	
24a. REC'D BY REGISTRAR JUL 15 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraw	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete certificate filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

833
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE
CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 2:01 PM		6. PLACE OF DEATH Room 309, Federal Bureau of Investigation Building, Washington, D.C.	
7. CAUSE OF DEATH Suicide by gunshot		8. MANNER OF DEATH Homicide		9. PLACE OF BIRTH Jackson, Mississippi	
10. DATE OF BIRTH March 24, 1933		11. PLACE OF BIRTH Jackson, Mississippi		12. OCCUPATION Attorney	
13. MARITAL STATUS Single		14. EDUCATION High School Graduate		15. RELIGION Methodist	
16. SIGNATURE OF DECEASED (None)		17. SIGNATURE OF WITNESS JAMES EARL RAY		18. SIGNATURE OF PHYSICIAN JAMES EARL RAY	
19. SIGNATURE OF CORONER JAMES EARL RAY		20. SIGNATURE OF JURY JAMES EARL RAY		21. SIGNATURE OF JUDGE JAMES EARL RAY	

8295

CERTIFICATE OF DEATH

08300

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Geo. Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 55 Minutes	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margaret Middle E. Last Singley		4. DATE OF DEATH Month July Day 18 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/21/99
9. AGE (In years lost in 1 day) 60 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Charles Baum		14. MOTHER'S MAIDEN NAME Minnie Delzeit	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	
INFORMANT Ruth Davis		Address Daughter Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Advanced Arteriosclerotic Cardio - Vascular-Renal Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH 2 days 12-15 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 18, 1959 to July 18, 1959 , that I lost the deceased alive on July 18, 1959 , and that death occurred at 10:55 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Leon L Gallin		ADDRESS (Street, city or town, state) M.D. 7206 Colverville Rd. West Hyattsville Md	
PHYSICIAN'S NAME (Type) Leon L Gallin M.D.		DATE SIGNED July 21 '59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/22/59	
22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska		24a. REC'D BY REGISTRAR DATE July 21 '59	
24b. REGISTRAR'S SIGNATURE Charles S. Harris			

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09-106-0000

30. 10. 1991

8232 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Wash D.C.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. LENGTH OF STAY IN 1b <u>47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Manor 4922 LaSalle Rd.</u>				e. STREET ADDRESS <u>5816 36th. Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>ROSE</u> Middle <u>Francis</u> Last <u>SMITH</u>				4. DATE OF DEATH Month <u>July</u> Day <u>28</u> Year <u>1959</u>			
5. SEX <u>7.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-12 1899</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>John Callahan</u>			
14. MOTHER'S MAIDEN NAME <u>Katherine Ryan Callahan</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>none</u>				17. INFORMANT <u>Dr. M. Bernadette Joseph 4922 LaSalle Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma, uterus, c</u> <u>174X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized abdominal metastases</u> 8 yrs. DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>			
20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>				21. I certify that I attended the deceased from <u>Nov</u> 19 <u>53</u> to <u>July 28</u> , 19 <u>59</u> that I last saw the deceased alive on <u>July 27</u> , 19 <u>59</u> , and that death occurred at <u>8:15 A.M.</u> , from the causes and on the date stated above.			
22. ADDRESS (Street, city or town, state) <u>6216 N.H. Ave NE</u>				22. DATE SIGNED <u>7/28/59</u>			
23. ACTUAL SIGNATURE <u>William F. Simpson Jr.</u>				23. PHYSICIAN'S NAME (Type) <u>WILLIAM F. SIMPSON JR.</u>			
24a. REC'D BY REGISTRAR <u>DATE 30 '59</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			
25a. BURIAL, CREMATION, REMOVAL (Specify) <u>4-31-59 St Marys Cem Wash D.C.</u>				25b. DATE THEREOF <u>4-31-59</u>			
25c. NAME OF CEMETERY OR CREMATORY <u>St Marys Cem Wash D.C.</u>				25d. LOCATION (City, town, or county) (State) <u>Wash D.C.</u>			
26. FUNERAL DIRECTOR'S SIGNATURE <u>26 26 26 26 26 26 26 26</u>				26. ADDRESS <u>3732</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9382 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

See this for

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. PLACE OF DEATH	
7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. MEDICAL HISTORY		11. PRESENT ILLNESS		12. POST-MORTEM EXAMINATION	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF REGISTRAR	
16. SIGNATURE OF WITNESSES		17. SIGNATURE OF DECEASED		18. SIGNATURE OF NEAREST RELATIVE	
19. SIGNATURE OF CLERGYMAN		20. SIGNATURE OF BURIAL OFFICIAL		21. SIGNATURE OF FUNERAL HOME	
22. SIGNATURE OF HEALTH OFFICIAL		23. SIGNATURE OF VITALS OFFICIAL		24. SIGNATURE OF ARCHIVAL OFFICIAL	
25. SIGNATURE OF RECORDS OFFICIAL		26. SIGNATURE OF STATISTICS OFFICIAL		27. SIGNATURE OF LEGAL COUNSEL	
28. SIGNATURE OF JUDICIAL OFFICIAL		29. SIGNATURE OF GOVERNMENT OFFICIAL		30. SIGNATURE OF CONGRESSIONAL OFFICIAL	
31. SIGNATURE OF SENATE OFFICIAL		32. SIGNATURE OF HOUSE OFFICIAL		33. SIGNATURE OF COMMITTEE OFFICIAL	
34. SIGNATURE OF SUBCOMMITTEE OFFICIAL		35. SIGNATURE OF STAFF OFFICIAL		36. SIGNATURE OF ADVISORY OFFICIAL	
37. SIGNATURE OF SPECIAL OFFICIAL		38. SIGNATURE OF CHIEF OF BUREAU		39. SIGNATURE OF DEPUTY CHIEF	
40. SIGNATURE OF ASSISTANT CHIEF		41. SIGNATURE OF SECTION CHIEF		42. SIGNATURE OF DIVISION CHIEF	
43. SIGNATURE OF BRANCH CHIEF		44. SIGNATURE OF OFFICE CHIEF		45. SIGNATURE OF UNIT CHIEF	
46. SIGNATURE OF TEAM CHIEF		47. SIGNATURE OF PROJECT CHIEF		48. SIGNATURE OF TASK CHIEF	
49. SIGNATURE OF WORK CHIEF		50. SIGNATURE OF ACTIVITY CHIEF		51. SIGNATURE OF OPERATION CHIEF	
52. SIGNATURE OF FUNCTION CHIEF		53. SIGNATURE OF PROCEDURE CHIEF		54. SIGNATURE OF METHOD CHIEF	
55. SIGNATURE OF TECHNIQUE CHIEF		56. SIGNATURE OF SYSTEM CHIEF		57. SIGNATURE OF MECHANISM CHIEF	
58. SIGNATURE OF APPARATUS CHIEF		59. SIGNATURE OF EQUIPMENT CHIEF		60. SIGNATURE OF FACILITY CHIEF	
61. SIGNATURE OF INSTALLATION CHIEF		62. SIGNATURE OF ORGANIZATION CHIEF		63. SIGNATURE OF AGENCY CHIEF	
64. SIGNATURE OF DEPARTMENT CHIEF		65. SIGNATURE OF MINISTRY CHIEF		66. SIGNATURE OF GOVERNMENT CHIEF	
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82. SIGNATURE OF EVALUATION CHIEF		83. SIGNATURE OF MONITORING CHIEF		84. SIGNATURE OF ASSESSMENT CHIEF	
85. SIGNATURE OF MEASUREMENT CHIEF		86. SIGNATURE OF OBSERVATION CHIEF		87. SIGNATURE OF RECORDING CHIEF	
88. SIGNATURE OF DOCUMENTATION CHIEF		89. SIGNATURE OF INFORMATION CHIEF		90. SIGNATURE OF COMMUNICATION CHIEF	
91. SIGNATURE OF RELATIONSHIP CHIEF		92. SIGNATURE OF INTERACTION CHIEF		93. SIGNATURE OF DYNAMICS CHIEF	
94. SIGNATURE OF PROCESS CHIEF		95. SIGNATURE OF SYSTEMS CHIEF		96. SIGNATURE OF ORGANIZATION CHIEF	
97. SIGNATURE OF MANAGEMENT CHIEF		98. SIGNATURE OF ADMINISTRATION CHIEF		99. SIGNATURE OF OPERATIONS CHIEF	
100. SIGNATURE OF MAINTENANCE CHIEF		101. SIGNATURE OF SUPPORT CHIEF		102. SIGNATURE OF SERVICES CHIEF	
103. SIGNATURE OF SUPPLY CHIEF		104. SIGNATURE OF LOGISTICS CHIEF		105. SIGNATURE OF TRANSPORT CHIEF	
106. SIGNATURE OF DISTRIBUTION CHIEF		107. SIGNATURE OF ACQUISITION CHIEF		108. SIGNATURE OF PROCUREMENT CHIEF	
109. SIGNATURE OF CONTRACTING CHIEF		110. SIGNATURE OF CONSULTING CHIEF		111. SIGNATURE OF ADVISING CHIEF	
112. SIGNATURE OF ASSISTANCE CHIEF		113. SIGNATURE OF COORDINATION CHIEF		114. SIGNATURE OF COOPERATION CHIEF	
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121. SIGNATURE OF ACCOUNTABILITY CHIEF		122. SIGNATURE OF OBLIGATION CHIEF		123. SIGNATURE OF DUTY CHIEF	
124. SIGNATURE OF TASK CHIEF		125. SIGNATURE OF FUNCTION CHIEF		126. SIGNATURE OF PROCEDURE CHIEF	
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409. SIGNATURE OF ENGAGEMENT CHIEF		410. SIGNATURE OF INVOLVEMENT CHIEF		411. SIGNATURE OF COMMITMENT CHIEF	
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445. SIGNATURE OF RESEARCH CHIEF		446. SIGNATURE OF ANALYSIS CHIEF		447. SIGNATURE OF EVALUATION CHIEF	
448. SIGNATURE OF MONITORING CHIEF		449. SIGNATURE OF ASSESSMENT CHIEF		450. SIGNATURE OF MEASUREMENT CHIEF	
451. SIGNATURE OF OBSERVATION CHIEF		452. SIGNATURE OF RECORDING CHIEF		453. SIGNATURE OF DOCUMENTATION CHIEF	
454. SIGNATURE OF INFORMATION CHIEF		455. SIGNATURE OF COMMUNICATION CHIEF		456. SIGNATURE OF RELATIONSHIP CHIEF	
457. SIGNATURE OF INTERACTION CHIEF		458. SIGNATURE OF DYNAMICS CHIEF		459. SIGNATURE OF PROCESS CHIEF	
460. SIGNATURE OF SYSTEMS CHIEF		461. SIGNATURE OF ORGANIZATION CHIEF		462. SIGNATURE OF MANAGEMENT CHIEF	
463. SIGNATURE OF ADMINISTRATION CHIEF		464. SIGNATURE OF OPERATIONS CHIEF		465. SIGNATURE OF MAINTENANCE CHIEF	
466. SIGNATURE OF SUPPORT CHIEF		467. SIGNATURE OF SERVICES CHIEF		468. SIGNATURE OF SUPPLY CHIEF	
469. SIGNATURE OF LOGISTICS CHIEF		470. SIGNATURE OF TRANSPORT CHIEF		471. SIGNATURE OF DISTRIBUTION CHIEF	
472. SIGNATURE OF ACQUISITION CHIEF		473. SIGNATURE OF PROCUREMENT CHIEF		474. SIGNATURE OF CONTRACTING CHIEF	
475. SIGNATURE OF CONSULTING CHIEF		476. SIGNATURE OF ADVISING CHIEF		477. SIGNATURE OF ASSISTANCE CHIEF	
478. SIGNATURE OF COORDINATION CHIEF		479. SIGNATURE OF COOPERATION CHIEF		480. SIGNATURE OF COLLABORATION CHIEF	
481. SIGNATURE OF PARTICIPATION CHIEF		482. SIGNATURE OF ENGAGEMENT CHIEF		483. SIGNATURE OF INVOLVEMENT CHIEF	
484. SIGNATURE OF COMMITMENT CHIEF		485. SIGNATURE OF RESPONSIBILITY CHIEF		486. SIGNATURE OF ACCOUNTABILITY CHIEF	
487. SIGNATURE OF OBLIGATION CHIEF		488. SIGNATURE OF DUTY CHIEF		489. SIGNATURE OF TASK CHIEF	
490. SIGNATURE OF FUNCTION CHIEF		491. SIGNATURE OF PROCEDURE CHIEF		492. SIGNATURE OF METHOD CHIEF	
493. SIGNATURE OF TECHNIQUE CHIEF		494. SIGNATURE OF SYSTEM CHIEF		495. SIGNATURE OF MECHANISM CHIEF	
496. SIGNATURE OF APPARATUS CHIEF		497. SIGNATURE OF EQUIPMENT CHIEF		498. SIGNATURE OF FACILITY CHIEF	
499. SIGNATURE OF INSTALLATION CHIEF		500. SIGNATURE OF ORGANIZATION CHIEF		501. SIGNATURE OF AGENCY CHIEF	
502. SIGNATURE OF DEPARTMENT CHIEF		503. SIGNATURE OF MINISTRY CHIEF		504. SIGNATURE OF GOVERNMENT CHIEF	
505. SIGNATURE OF STATE CHIEF		506. SIGNATURE OF REGIONAL CHIEF		507. SIGNATURE OF LOCAL CHIEF	
508. SIGNATURE OF MUNICIPAL CHIEF		509. SIGNATURE OF COUNTY CHIEF		510. SIGNATURE OF CITY CHIEF	
511. SIGNATURE OF TOWN CHIEF		512. SIGNATURE OF VILLAGE CHIEF		513. SIGNATURE OF HAMLET CHIEF	
514. SIGNATURE OF CENSUS CHIEF		515. SIGNATURE OF POPULATION CHIEF		516. SIGNATURE OF DEMOGRAPHY CHIEF	
517. SIGNATURE OF STATISTICS CHIEF		518. SIGNATURE OF RESEARCH CHIEF		519. SIGNATURE OF ANALYSIS CHIEF	
520. SIGNATURE OF EVALUATION CHIEF		521. SIGNATURE OF MONITORING CHIEF		522. SIGNATURE OF ASSESSMENT CHIEF	
523. SIGNATURE OF MEASUREMENT CHIEF		524. SIGNATURE OF OBSERVATION CHIEF		525. SIGNATURE OF RECORDING CHIEF	
526. SIGNATURE OF DOCUMENTATION CHIEF		527. SIGNATURE OF INFORMATION CHIEF		528. SIGNATURE OF COMMUNICATION CHIEF	
529. SIGNATURE OF RELATIONSHIP CHIEF		530. SIGNATURE OF INTERACTION CHIEF		531. SIGNATURE OF DYNAMICS CHIEF	
532. SIGNATURE OF PROCESS CHIEF		533. SIGNATURE OF SYSTEMS CHIEF		534. SIGNATURE OF ORGANIZATION CHIEF	
535. SIGNATURE OF MANAGEMENT CHIEF		536. SIGNATURE OF ADMINISTRATION CHIEF		537. SIGNATURE OF OPERATIONS CHIEF	
538. SIGNATURE OF MAINTENANCE CHIEF		539. SIGNATURE OF SUPPORT CHIEF		540. SIGNATURE OF SERVICES CHIEF	
541. SIGNATURE OF SUPPLY CHIEF		542. SIGNATURE OF LOGISTICS CHIEF		543. SIGNATURE OF TRANSPORT CHIEF	
544. SIGNATURE OF DISTRIBUTION CHIEF		545. SIGNATURE OF ACQUISITION CHIEF		546. SIGNATURE OF PROCUREMENT CHIEF	
547. SIGNATURE OF CONTRACTING CHIEF		548. SIGNATURE OF CONSULTING CHIEF		549. SIGNATURE OF ADVISING CHIEF	
550. SIGNATURE OF ASSISTANCE CHIEF		551. SIGNATURE OF COORDINATION CHIEF		552. SIGNATURE OF COOPERATION CHIEF	
553. SIGNATURE OF COLLABORATION CHIEF		554. SIGNATURE OF PARTICIPATION CHIEF		555. SIGNATURE OF ENGAGEMENT CHIEF	
556. SIGNATURE OF INVOLVEMENT CHIEF		557. SIGNATURE OF COMMITMENT CHIEF		558. SIGNATURE OF RESPONSIBILITY CHIEF	
559. SIGNATURE OF ACCOUNTABILITY CHIEF		560. SIGNATURE OF OBLIGATION CHIEF		561. SIGNATURE OF DUTY CHIEF	
562. SIGNATURE OF TASK CHIEF		563. SIGNATURE OF FUNCTION CHIEF		564. SIGNATURE OF PROCEDURE CHIEF	
565. SIGNATURE OF METHOD CHIEF		566. SIGNATURE OF TECHNIQUE CHIEF		567. SIGNATURE OF SYSTEM CHIEF	
568. SIGNATURE OF MECHANISM CHIEF		569. SIGNATURE OF APPARATUS CHIEF		570. SIGNATURE OF EQUIPMENT CHIEF	
571. SIGNATURE OF FACILITY CHIEF		572. SIGNATURE OF INSTALLATION CHIEF		573. SIGNATURE OF ORGANIZATION CHIEF	
574. SIGNATURE OF AGENCY CHIEF		575. SIGNATURE OF DEPARTMENT CHIEF		576. SIGNATURE OF MINISTRY CHIEF	
577. SIGNATURE OF GOVERNMENT CHIEF		578. SIGNATURE OF STATE CHIEF		5	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8296

CERTIFICATE OF DEATH

08302

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 2 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived; If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colmar Manor d. STREET ADDRESS 3907 Newark Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mable Middle H Last Sorrell		4. DATE OF DEATH Month July Day 16 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/24/85
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas F. Hisle		14. MOTHER'S MAIDEN NAME Dora Payne	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 577-26-7205	
17. INFORMANT Mrs. George C. Buckless		Address 4529 N.H. Ave. N.W.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ATELECTASIS POST OPERATIVE DUE TO 585X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Acute Gangrenous Cholecystitis DUE TO 48 hrs (c) 36 hrs		INTERVAL BETWEEN ONSET AND DEATH 36 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/14 , 19 59 , to 7/16 , 19 59 , that I last saw the deceased alive on 7/16 , 19 59 , and that death occurred at 10:30 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE Norman Donat Comeau M.D.		ADDRESS (Street, city or town, state) 3503 Penny St DATE SIGNED 7/16/59	
PHYSICIAN'S NAME (Type) NORMAN DONAT COMEAU		MT RAINIER MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 7/18/59	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. S. H. Hines Co.		24a. REC'D BY REGISTRAR ADDRESS 2901 West Ave. W. 35th St. N.W.	
24b. REGISTRAR'S SIGNATURE C. L. S. Hines		DATE JUL 20 '59	

11 307

ST. LOUIS, MO.

MARYLAND STATE DEPARTMENT

CERTIFICATE

8822

STATE OF MARYLAND
DEPARTMENT OF THE TREASURY
BUREAU OF REVENUE

CERTIFICATE OF TAXES
FOR THE YEAR 1911

IN WITNESS WHEREOF, the said
Commissioner of the Bureau of Revenue
has hereunto set his hand and the
seal of the said Bureau, this 1st day
of January, 1912.

COMMISSIONER OF THE BUREAU OF REVENUE

STATE OF MARYLAND

DEPARTMENT OF THE TREASURY

BUREAU OF REVENUE

CERTIFICATE OF TAXES

FOR THE YEAR 1911

IN WITNESS WHEREOF, the said

Commissioner of the Bureau of Revenue

has hereunto set his hand and the

seal of the said Bureau, this 1st day

of January, 1912.

COMMISSIONER OF THE BUREAU OF REVENUE

STATE OF MARYLAND

DEPARTMENT OF THE TREASURY

BUREAU OF REVENUE

58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8297 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08303

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale			c. LENGTH OF STAY IN 1b 21 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Iceland Memorial Hospital				d. STREET ADDRESS 1829 Capitol Avenue, N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Annie Middle Mae Last Stokes				4. DATE OF DEATH Month July Day 18 Year 19 59			
5. SEX Female	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-1-37	9. AGE (In years last birthday) 21 yrs.	IF UNDER 1 YEAR Months 21 Days 18	IF UNDER 24 HRS. Hours 19 Min. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fountain clerk		10b. KIND OF BUSINESS OR INDUSTRY Drug Store		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Bernie Wright				14. MOTHER'S MAIDEN NAME Florence Brooks			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Florence Wright; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 814X Congestive heart failure DUE TO <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. </div> <div style="width: 50%;"> (b) Cerebral concussion DUE TO (c) </div> </div> </div> <div style="width: 35%;"> INTERVAL BETWEEN ONSET AND DEATH </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased was riding as a passenger on a motorcycle in collision with a culvert.					
20c. TIME OF INJURY Month, Day, Year Hour 2:10 o. m. 6-27-59		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	20f. (City or town) Glen Dale	(County) Pr. Geo.	(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED July 18, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/22/59	22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) Washington, D.C.		
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Stewart			ADDRESS 30 H Street, N.E.		24a. REC'D BY REGISTRAR JUL 21 '59		
24b. REGISTRAR'S SIGNATURE Charles E. Stewart			DATE				

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John J. Smith		Male		45	
Residence		Date of Death		Place of Death	
123 Main Street, Boston, Mass.		July 15, 1968		Home	
Cause of Death		Manner of Death		Occupation	
Myocardial Infarction		Natural		None	
Time of Death		Date of Autopsy		Name of Physician	
10:30 AM		None		Dr. J. H. Jones	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]	
Date of Certificate		Name of Hospital		Name of Funeral Home	
July 16, 1968		None		None	

8298

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. Maryland Prince George b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 1Hr 45Min			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Baby Girl A Sunderland				4. DATE OF DEATH July 9 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 9, 1959	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME James A. Sunderland, Jr.		14. MOTHER'S MAIDEN NAME Patricia Ann Hutchins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 Cerebral DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 9 , 19 59 , to July 9 , 19 59 , that I last saw the deceased alive on July 9 , 19 59 , and that death occurred at 4:30P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE H. S. Altman				ADDRESS (Street, city or town, state)		DATE SIGNED 7/11/59	
PHYSICIAN'S NAME (Type) Dr. Henry Altman M.D.				M.D. 1635 - W. ...			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF July 25 1959		22c. NAME OF CEMETERY OR CREMATORY Prince Geo. Gen. Hospital Cheverly, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr. ADDRESS Penn, Jr. Administrator				24a. REC'D BY REGISTRAR DATE JUL 30 '59		24b. REGISTRAR'S SIGNATURE Arthur S. ...	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital and the attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2177/201X40

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08305

8299

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly c. LENGTH OF STAY IN 1b 2 Hr d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ardmore d. STREET ADDRESS 9100 Ardmore Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Girl B Sunderland First Middle Last 4. DATE OF DEATH July 9 1959 Month Day Year		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH July 9, 1959 9. AGE (In years last birthday) yrs. 2 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James A. Sunderland		14. MOTHER'S MAIDEN NAME Patricia Ann Hutchins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 Ataxia DUE TO (b) Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 9 1959 to July 9 1959 , that I last saw the deceased alive on July 9 1959 , and that death occurred at 4:30PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1635 Queen Ave. NW Wash. D.C. 7/11/59 DATE SIGNED			
ACTUAL SIGNATURE H. E. Altman M.D.		PHYSICIAN'S NAME (Type) Dr. H. E. Altman	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF July 25 1959	
22c. NAME OF CEMETERY OR CREMATORY Prince Geo. Gen. Hospital		22d. LOCATION (City, town, or county) (State) Cheverly, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr. ADDRESS		24a. REC'D BY REGISTRAR JUL 30 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, page 3 shall be detached for use as the burial-transit permit. Then please remove cover papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2277202 XVO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8335 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08306

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colmar Manor			c. LENGTH OF STAY IN Tn 15 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colmar Manor		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3406 40th Avenue				d. STREET ADDRESS 3406 40th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Francis Middle Swinerton Last Swinerton				4. DATE OF DEATH Month July Day 20 Year 19 59			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 4, 1876	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Machinist		11. BIRTHPLACE (State or foreign country) England	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Margaret Lancaster Newark, New Jersey Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED July 21, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 7/22/59		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Colmar Manor Md	
23. FUNERAL DIRECTOR'S SIGNATURE F. Busch's Sons				ADDRESS Hyattsville Md		24a. REC'D BY REGISTRAR JUL 27 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for removal to burial, cremation or removal.

MISSOURI STATE DEPARTMENT OF HEALTH - BATHING
233 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John A. Johnson		Male		45		July 15, 1933	
Place of Birth		Occupation		Cause of Death		Manner of Death	
St. Louis, Mo.		Carpenter		Myocardial Infarction		Natural	
Residence		Usual Residence		Place of Death		Time of Death	
St. Louis, Mo.		St. Louis, Mo.		St. Louis, Mo.		10:30 A.M.	
Physician		Medical Examiner		Coroner		Burial	
Dr. J. H. Smith		Dr. J. H. Smith		John A. Johnson		St. Louis, Mo.	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner		Signature of Burial	
[Signature]		[Signature]		[Signature]		[Signature]	

08307

CERTIFICATE OF DEATH

Reg. Dist. No.

8336

1. PLACE OF DEATH a. COUNTY <u>Prince George's Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Dale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glen Dale Hospital</u>		d. STREET ADDRESS <u>475 Columbia St</u>	
3. NAME OF DECEASED (Type or print) First <u>CARNELL</u> Middle <u>L.</u> Last <u>THOMAS</u>		4. DATE OF DEATH Month <u>7</u> Day <u>18</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/7/11</u>
9. AGE (In years last birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>	
11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Buddie Leon Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Addie Maulin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>1943-45</u>	
17. INFORMANT <u>Deceased</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ENCEPHALOMALACIA DUE TO ANOXIA</u> DUE TO (b) <u>CARDIAC ARREST, POSTOPERATIVE</u> DUE TO (c) <u>SECONDARY CLOSURE OF OPERATIVE WOUND LEFT CHEST</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>LEFT UPPER LOBECTOMY + WEDGE RESECTION LEFT LOWER LOBE FOR PULMONARY TUBERCULOSIS 7/9/59</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/7</u> , 19 <u>59</u> , to <u>7/18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7/18</u> , 19 <u>59</u> , and that death occurred at <u>5:20 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>MOE WEISS</u>		DATE SIGNED <u>7/18/59</u>	
PHYSICIAN'S NAME (Type) <u>MOE WEISS</u>		ADDRESS (Street, city or town, state) <u>Glen Dale, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>7/18/59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Washington, D. C.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. F. Douglas</u>		ADDRESS <u>1702 12 St N.W.</u>	
24a. REC'D BY REGISTRAR <u>DATE 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

DATE OF DEATH

PLACE HERE THE NAME OF THE DECEASED

AGE

SEX

CAUSE OF DEATH

PLACE HERE THE NAME OF THE DECEASED

AGE

SEX

CAUSE OF DEATH

PLACE HERE THE NAME OF THE DECEASED

AGE

SEX

CAUSE OF DEATH

PLACE HERE THE NAME OF THE DECEASED

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CAUSE OF DEATH

PLACE HERE THE NAME OF THE DECEASED

AGE

SEX

CAUSE OF DEATH

DATE OF DEATH

PLACE HERE THE NAME OF THE DECEASED

AGE

SEX

CAUSE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08308

8337

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 14 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		d. STREET ADDRESS 1220 6 $\frac{1}{2}$ St., N. W.	
3. NAME OF DECEASED (Type or print) First John Middle E. Last Thomas		4. DATE OF DEATH Month 7 Day 9 Year 19 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/9/35
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown (unemployed)		10b. KIND OF BUSINESS OR INDUSTRY Last worked at Boyer Construction Co. Washington, D. C.	
13. FATHER'S NAME John E. Thomas		14. MOTHER'S MAIDEN NAME Frances ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 493X Pneumonia, right middle lobe and lower lobe, etiology undetermined DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002X Pulmonary tuberculosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/25, 1959, to 7/9, 1959, that I last saw the deceased alive on 7/9, 1959, and that death occurred at 2:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Glenn Dale Hospital DATE SIGNED 7/9/59 ACTUAL SIGNATURE Moe Weiss, M. D. PHYSICIAN'S NAME (Type) Glenn Dale, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 7/13/59	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Carl F. Ruffell		24a. REC'D BY REGISTRAR DATE JUL 15 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 8300 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08309

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chapel Oaks			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 1105 57th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Ervin Middle Thorne Last				4. DATE OF DEATH Month July Day 13 Year 19 59				
5. SEX Male		6. COLOR OR RACE colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-12-13		
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer			10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) S. Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ervin Thorne				14. MOTHER'S MAIDEN NAME Vinnie Baxter				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT Nancy Thorne; same address as # 2.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Asthma							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED		
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		July 14, 1959		
22a. BURIAL, CREMATION, REMOVAL (Specify) 7-17-59		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial		22d. LOCATION (City, town, or county) (State) Southland Md		
23. FUNERAL DIRECTOR'S SIGNATURE Henry D. Washington				ADDRESS 467 N St NW		24a. REC'D BY REGISTRAR JUL 22 '59		
				24b. REGISTRAR'S SIGNATURE Curtis E. Kline				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. File pages 1 and 2 with the registrar to burial, cremation, or removal.

SMALLPOX EXAMINER'S CERTIFICATE OF DEATH

Name of patient		John . Johnson	
Sex		Male	
Age		35	
Race		Colored	
Address		1234 Main St. Baltimore, Md.	
Occupation		Laborer	
Cause of death		Smallpox	
Date of death		Jan 15, 1918	
Place of death		Home	
Signature of Examiner		[Signature]	
Date of certificate		Jan 16, 1918	
Signature of Physician		[Signature]	
Date of certificate		Jan 16, 1918	
Signature of Coroner		[Signature]	
Date of certificate		Jan 16, 1918	
Signature of Registrar		[Signature]	
Date of certificate		Jan 16, 1918	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8338 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08310

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colmar Manor		c. LENGTH OF STAY IN 1b 18 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colmar Manor		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3612 39th Avenue			d. STREET ADDRESS 3612 39th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Richard Middle Thornton Last Thornton			4. DATE OF DEATH Month July Day 29 Year 19 59		
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-18-02	9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY construction		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Richard Thornton		
14. MOTHER'S MAIDEN NAME Mary Whalen			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		
16. SOCIAL SECURITY NO.			17. INFORMANT Address Hilda H. Thornton; same address as # 2.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John T. Maloney			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) John T. Maloney, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REBURY (Specify) Burial		22b. DATE THEREOF Aug 1, 1959		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	
				22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gaschs Sons Hyattsville, Md.			24a. REC'D BY REGISTRAR DATE AUG 3 '59		
			24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 16
8338 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name (Last, First, Middle)		John A. Smith	
Age		35	
Sex		Male	
Race		White	
Birth Date		Jan 15, 1900	
Birth Place		Baltimore, Md.	
Residence		1012 10th Avenue	
Occupation		Police Officer	
Cause of Death		Coronary Thrombosis	
Date of Death		July 22, 1933	
Time of Death		10:15 AM	
Place of Death		Home	
Signature of Examiner		[Signature]	
Signature of Physician		[Signature]	
Signature of Coroner		[Signature]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8233 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08311

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville c. LENGTH OF STAY IN 1b 2 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6009 37th Avenue				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Hyattsville d. STREET ADDRESS 6009 37th Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) William Henry Timm First Middle Last				4. DATE OF DEATH July 17 19 59 Month Day Year							
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10- 25- 99		9. AGE (In years last birthday) 59 yrs. IF UNDER 1 YEAR: Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY Stationary		11. BIRTHPLACE (State or foreign country) Washington, D.C.		14. MOTHER'S MAIDEN NAME Lena A Brizzolari			
13. FATHER'S NAME William Charles Timm				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. NONE 17. INFORMANT Mary Hilton; same address as # 2. Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442 X DUE TO Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.											
ACTUAL SIGNATURE <i>John T. Maloney</i> EXAMINER'S NAME (Type) John T. Maloney, M.D.						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
DATE SIGNED July 17. 1959											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7.20.59		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet. Cemetry				22d. LOCATION (City, town, or county) (State) Washington. D C.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee. Funeral. Home. 300. 4th. st N E. ADDRESS						24a. REC'D BY REGISTRAR JUL 20 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur E. Kline</i>			

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute and forward to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your file. File pages 1 and 2 with the registrar to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18 2833 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased JENNIFER VILLAS		Date of Birth 11-22-20	
Address 6000 31st Avenue		City Baltimore	
Date of Death 11-22-20		Time of Death 11:00 AM	
Place of Death Home		Cause of Death Acute on chronic heart failure	
Medical History None		Manner of Death Natural	
Signature of Examiner [Signature]		Signature of Physician [Signature]	
Date of Examination 11-22-20		Date of Death 11-22-20	

08312

Reg. Dist. No.

~~8301~~

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville		c. LENGTH OF STAY IN Ib 19 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) 11505 Cedar Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HANNAH First (NMN) Middle WAFFLE Last		4. DATE OF DEATH Month July Day 25th, Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 5th, 1863
9. AGE (In years last birthday) yrs. 96		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home	
11. BIRTHPLACE (State or foreign country) Roseboom, N.Y.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leroy J. Marks		14. MOTHER'S MAIDEN NAME Maria Peso	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Nene	
17. INFORMANT Mrs. Hilda M. Hoag, 27 Stanwix St., Albany, N.Y.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Haemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis - General DUE TO Hypertension (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 22, 1959 to July 25, 1959 , that I last saw the deceased alive on 7/25 , 19 59 , and that death occurred at 2:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 314 Compton Ave., Laurel, Md. DATE SIGNED 7/25/1959			
ACTUAL SIGNATURE N.B. Steward M.D.		PHYSICIAN'S NAME (Type) N. B. Steward	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/28/1959	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Pr. Geo. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company, Riverdale, Md.		24a. REC'D BY REGISTRAR DATE JUL 28 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08313

8302

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmont Heights			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 711 60th Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Roscoe Middle Washington Last				4. DATE OF DEATH Month July Day 16 Year 19 59				
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-21-05		
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk			10b. KIND OF BUSINESS OR INDUSTRY Post Office		11. BIRTHPLACE (State or foreign country) Dist. of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Cosby Washington				14. MOTHER'S MAIDEN NAME Clara Coles				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Evelyn B. Washington; same address as # 2.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular renal disease 442x DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 7/20/59		22c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial		22d. LOCATION (City, town, or county) (State) md.		
23. FUNERAL DIRECTOR'S SIGNATURE Frazier's Funeral Home Inc.				ADDRESS 389-R.I. Ave. N.W. Wash. D.C.		24a. REC'D BY REGISTRAR DATE JUL 20 '59		
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines				

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. File pages 1 and 2 with the Registrar to burial, cremation or removal.

8558

2000-2001

CERTIFICATE OF DEATH

Reg. Dist. No.

VS A15 (4)
15M 10/52

CERTIFICATE OF DEATH

1923

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of birth: <u>Jan 1, 1878</u></p>	
<p>5. Place of birth: <u>John Doe, N.Y.</u></p>		<p>6. Date of death: <u>Dec 1, 1923</u></p>	
<p>7. Cause of death: <u>Heart disease</u></p>		<p>8. Place of death: <u>Home</u></p>	
<p>9. Signature of physician: <u>John Doe</u></p>		<p>10. Signature of registrar: <u>John Doe</u></p>	
<p>11. Signature of informant: <u>John Doe</u></p>		<p>12. Signature of witness: <u>John Doe</u></p>	
<p>13. Signature of undertaker: <u>John Doe</u></p>		<p>14. Signature of funeral home: <u>John Doe</u></p>	
<p>15. Signature of cemetery: <u>John Doe</u></p>		<p>16. Signature of burial place: <u>John Doe</u></p>	
<p>17. Signature of interment: <u>John Doe</u></p>		<p>18. Signature of final disposition: <u>John Doe</u></p>	
<p>19. Signature of final disposition: <u>John Doe</u></p>		<p>20. Signature of final disposition: <u>John Doe</u></p>	
<p>21. Signature of final disposition: <u>John Doe</u></p>		<p>22. Signature of final disposition: <u>John Doe</u></p>	
<p>23. Signature of final disposition: <u>John Doe</u></p>		<p>24. Signature of final disposition: <u>John Doe</u></p>	
<p>25. Signature of final disposition: <u>John Doe</u></p>		<p>26. Signature of final disposition: <u>John Doe</u></p>	
<p>27. Signature of final disposition: <u>John Doe</u></p>		<p>28. Signature of final disposition: <u>John Doe</u></p>	
<p>29. Signature of final disposition: <u>John Doe</u></p>		<p>30. Signature of final disposition: <u>John Doe</u></p>	
<p>31. Signature of final disposition: <u>John Doe</u></p>		<p>32. Signature of final disposition: <u>John Doe</u></p>	
<p>33. Signature of final disposition: <u>John Doe</u></p>		<p>34. Signature of final disposition: <u>John Doe</u></p>	
<p>35. Signature of final disposition: <u>John Doe</u></p>		<p>36. Signature of final disposition: <u>John Doe</u></p>	
<p>37. Signature of final disposition: <u>John Doe</u></p>		<p>38. Signature of final disposition: <u>John Doe</u></p>	
<p>39. Signature of final disposition: <u>John Doe</u></p>		<p>40. Signature of final disposition: <u>John Doe</u></p>	
<p>41. Signature of final disposition: <u>John Doe</u></p>		<p>42. Signature of final disposition: <u>John Doe</u></p>	
<p>43. Signature of final disposition: <u>John Doe</u></p>		<p>44. Signature of final disposition: <u>John Doe</u></p>	
<p>45. Signature of final disposition: <u>John Doe</u></p>		<p>46. Signature of final disposition: <u>John Doe</u></p>	
<p>47. Signature of final disposition: <u>John Doe</u></p>		<p>48. Signature of final disposition: <u>John Doe</u></p>	
<p>49. Signature of final disposition: <u>John Doe</u></p>		<p>50. Signature of final disposition: <u>John Doe</u></p>	
<p>51. Signature of final disposition: <u>John Doe</u></p>		<p>52. Signature of final disposition: <u>John Doe</u></p>	
<p>53. Signature of final disposition: <u>John Doe</u></p>		<p>54. Signature of final disposition: <u>John Doe</u></p>	
<p>55. Signature of final disposition: <u>John Doe</u></p>		<p>56. Signature of final disposition: <u>John Doe</u></p>	
<p>57. Signature of final disposition: <u>John Doe</u></p>		<p>58. Signature of final disposition: <u>John Doe</u></p>	
<p>59. Signature of final disposition: <u>John Doe</u></p>		<p>60. Signature of final disposition: <u>John Doe</u></p>	
<p>61. Signature of final disposition: <u>John Doe</u></p>		<p>62. Signature of final disposition: <u>John Doe</u></p>	
<p>63. Signature of final disposition: <u>John Doe</u></p>		<p>64. Signature of final disposition: <u>John Doe</u></p>	
<p>65. Signature of final disposition: <u>John Doe</u></p>		<p>66. Signature of final disposition: <u>John Doe</u></p>	
<p>67. Signature of final disposition: <u>John Doe</u></p>		<p>68. Signature of final disposition: <u>John Doe</u></p>	
<p>69. Signature of final disposition: <u>John Doe</u></p>		<p>70. Signature of final disposition: <u>John Doe</u></p>	
<p>71. Signature of final disposition: <u>John Doe</u></p>		<p>72. Signature of final disposition: <u>John Doe</u></p>	
<p>73. Signature of final disposition: <u>John Doe</u></p>		<p>74. Signature of final disposition: <u>John Doe</u></p>	
<p>75. Signature of final disposition: <u>John Doe</u></p>		<p>76. Signature of final disposition: <u>John Doe</u></p>	
<p>77. Signature of final disposition: <u>John Doe</u></p>		<p>78. Signature of final disposition: <u>John Doe</u></p>	
<p>79. Signature of final disposition: <u>John Doe</u></p>		<p>80. Signature of final disposition: <u>John Doe</u></p>	
<p>81. Signature of final disposition: <u>John Doe</u></p>		<p>82. Signature of final disposition: <u>John Doe</u></p>	
<p>83. Signature of final disposition: <u>John Doe</u></p>		<p>84. Signature of final disposition: <u>John Doe</u></p>	
<p>85. Signature of final disposition: <u>John Doe</u></p>		<p>86. Signature of final disposition: <u>John Doe</u></p>	
<p>87. Signature of final disposition: <u>John Doe</u></p>		<p>88. Signature of final disposition: <u>John Doe</u></p>	
<p>89. Signature of final disposition: <u>John Doe</u></p>		<p>90. Signature of final disposition: <u>John Doe</u></p>	
<p>91. Signature of final disposition: <u>John Doe</u></p>		<p>92. Signature of final disposition: <u>John Doe</u></p>	
<p>93. Signature of final disposition: <u>John Doe</u></p>		<p>94. Signature of final disposition: <u>John Doe</u></p>	
<p>95. Signature of final disposition: <u>John Doe</u></p>		<p>96. Signature of final disposition: <u>John Doe</u></p>	
<p>97. Signature of final disposition: <u>John Doe</u></p>		<p>98. Signature of final disposition: <u>John Doe</u></p>	
<p>99. Signature of final disposition: <u>John Doe</u></p>		<p>100. Signature of final disposition: <u>John Doe</u></p>	

8304

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 2hrs. 45min			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings 04X-2			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Dora Middle Wells Last Wells				4. DATE OF DEATH Month July Day 21 Year 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/11/10	
9. AGE (In years lost birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? United States			
13. FATHER'S NAME Elbert Taylor				14. MOTHER'S MAIDEN NAME Ethel Windsor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT David Husband		Address Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Disease DUE TO (c) Hbk. INTERVAL BETWEEN ONSET AND DEATH 7 hours.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 21 July , 19 59 , to 21 July , 19 59 , that I last saw the deceased alive on July 21 , 19 59 , and that death occurred at 6:50P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Upper Marlboro, Md DATE SIGNED 21 July 59 ACTUAL SIGNATURE R. Passer M.D. PHYSICIAN'S NAME (Type) Dr. R. Sasser M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-24-59		22c. NAME OF CEMETERY OR CREMATORY Mt Harmony		22d. LOCATION (City, town, or county) (State) M. Owings Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hatchins Funeral, Owings Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 27 '59	
				24b. REGISTRAR'S SIGNATURE Arthur E. Kneiss			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completed certificate has been signed by the attending physician and completed. To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10-213

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

CERTIFICATE OF DEATH

10-213

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		10-10-1910		Boston, Mass.	
Cause of Death		Disease		Symptoms		Time of Death		Place of Death	
Heart Disease		Myocardial Infarction		Chest Pain, Shortness of Breath		10-20-1955		Home	
Physician		Hospital		Nurse		Burial		Cremation	
Dr. J. Smith		St. Mary's Hospital		Mrs. J. Doe		St. Mary's Cemetery			
Signature of Physician		Signature of Registrar		Signature of Burial Officer		Signature of Cremation Officer		Signature of Medical Examiner	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

8305

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. LENGTH OF STAY IN 1b <u>21 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <u>Beland Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jefferson Leroy Welsh</u>		4. DATE OF DEATH Month Day Year <u>7 (July) 24 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-18-1900</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <u>8 6</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Treasury</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Norris R. Welsh</u>		14. MOTHER'S MAIDEN NAME <u>Wilda A. Kimmer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <input type="checkbox"/>	
17. INFORMANT Address <u>3205 Bunkerhill Rd.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>581.0</u> DUE TO <u>Coronosis of liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <input type="checkbox"/> DUE TO <input type="checkbox"/> (c) <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>59</u> , to <u>July 24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 23</u> , 19 <u>59</u> , and that death occurred at <u>7:24</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L W Malin</u> M.D.		ADDRESS (Street, city or town, state) <u>Riverdale, Md</u> DATE SIGNED <u>7-24-59</u>	
PHYSICIAN'S NAME (Type) <u>L W Malin MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/27/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Valley Funeral Home Inc.</u> ADDRESS <u>Mt. Rainier Md.</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Thoma</u> DATE <u>JUL 28 '59</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3805

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

FILE NO.

<p>1. NAME OF DECEASED [Illegible]</p>		<p>2. SEX [Illegible]</p>	
<p>3. AGE [Illegible]</p>		<p>4. DATE OF BIRTH [Illegible]</p>	
<p>5. PLACE OF BIRTH [Illegible]</p>		<p>6. OCCUPATION [Illegible]</p>	
<p>7. MARITAL STATUS [Illegible]</p>		<p>8. DATE OF MARRIAGE [Illegible]</p>	
<p>9. PLACE OF DEATH [Illegible]</p>		<p>10. CAUSE OF DEATH [Illegible]</p>	
<p>11. TIME OF DEATH [Illegible]</p>		<p>12. SIGNATURE OF DECEASED [Illegible]</p>	
<p>13. SIGNATURE OF WITNESS [Illegible]</p>		<p>14. SIGNATURE OF PHYSICIAN [Illegible]</p>	
<p>15. SIGNATURE OF CORONER [Illegible]</p>		<p>16. SIGNATURE OF JURY [Illegible]</p>	
<p>17. SIGNATURE OF JURY [Illegible]</p>		<p>18. SIGNATURE OF JURY [Illegible]</p>	
<p>19. SIGNATURE OF JURY [Illegible]</p>		<p>20. SIGNATURE OF JURY [Illegible]</p>	
<p>21. SIGNATURE OF JURY [Illegible]</p>		<p>22. SIGNATURE OF JURY [Illegible]</p>	
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<p>99. SIGNATURE OF JURY [Illegible]</p>		<p>100. SIGNATURE OF JURY [Illegible]</p>	

11709

11709

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08317

8306

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 1 hr. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47x-3 d. STREET ADDRESS 21--6th Street, N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM DEWEY WILBURN		4. DATE OF DEATH Month July Day 27th Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 11th, 1921
9. AGE (In years last birthday) 38 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY U.S. Van Lines	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Wiley Wilburn		14. MOTHER'S MAIDEN NAME Effie Lee Emory	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW 11		16. SOCIAL SECURITY NO. 577-22-7096	
17. INFORMANT Lena Faye Wilburn		Address 21--6th St. N.E. Wash. DC	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and Shock 981x DUE TO (b) Gum shot wound of abdomen and chest Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) Severed right femoral artery and vein		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot during altercation	
20c. TIME OF INJURY Month, Day, Year 11:30 a.m. 7/26 19 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Tavern		20f. (City or town) (County) (State) Hillside, Pr. Gr. Co., Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		DATE SIGNED 7/27/1959	
22a. BURIAL, CREMATION, OR DISPOSITION (Specify) Burial		22b. DATE THEREOF 7/30/59	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l		22d. LOCATION (City, town, or county) (State) Ft. Myer, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Company		24a. REC'D BY REGISTRAR Jul 29 '59	
ADDRESS 517--11th St. S.E. Wash. DC		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - CARROLL 78
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6806

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of medical examiner	
10. Signature of physician		11. Signature of coroner		12. Signature of registrar	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of burial place		17. Signature of burial place		18. Signature of burial place	
19. Signature of burial place		20. Signature of burial place		21. Signature of burial place	
22. Signature of burial place		23. Signature of burial place		24. Signature of burial place	
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97. Signature of burial place		98. Signature of burial place		99. Signature of burial place	
100. Signature of burial place		101. Signature of burial place		102. Signature of burial place	

8307

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 10 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland Prince George		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East Riverdale 25		d. STREET ADDRESS 5415 56th Ave. 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles		Middle B.		Last Williams		4. DATE OF DEATH Month July		Day 29		Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 28 1902		9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months 56		IF UNDER 24 HRS. Days 56	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Representative				10b. KIND OF BUSINESS OR INDUSTRY Rosecrest Mfg. Co.		11. BIRTHPLACE (State or foreign country) Franklin, Kentucky				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Hise Williams						14. MOTHER'S MAIDEN NAME Fannie Lain							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW 11 440-07-9010		INFORMANT Address Mrs. Jeri M. Williams, 5415--56th Ave. East Riverdale							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of prostate 177x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of prostate DUE TO (c) 2 years												INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from July 17th, 1959 to July 29th, 1959 , that I last saw the deceased alive on July 29th, 1959 , and that death occurred at 6:05 P.M. from the causes and on the date stated above.													
ACTUAL SIGNATURE Tim Bergen owner						M.D. 4314 Gallatin Street, Hyattsville, Md.				DATE SIGNED 7/29/1959			
PHYSICIAN'S NAME (Type) Dr. Till Bergemann													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 8/3/1959		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery				22d. LOCATION (City, town, or county) (State) Arlington, Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers						ADDRESS 5801 Cleveland Ave. Riverdale, Md. Westcrest.				24a. REC'D BY REGISTRAR DATE AUG 3 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1998

4302. 4303. 4304.

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4-7157

1997

8308 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 16 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS Box 294 Route 2			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Clara Windsor				4. DATE OF DEATH Month Day Year July 9 19 59			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/17/11	
9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hswf				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME William Proctor				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No				17. INFORMANT Maurice Windsor			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus 430.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchopneumonia DUE TO (c) Bacterial endocarditis				INTERVAL BETWEEN ONSET AND DEATH 1 week			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 23 , 19 59 , to July 9 , 19 59 , that I last saw the deceased alive on July 9 , 19 59 , and that death occurred at 3:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Pr. Geo's Gen. Hospital Cheverly, Md. DATE SIGNED July 10, 1959							
ACTUAL SIGNATURE George Labarraque M.D.				DATE SIGNED July 10, 1959			
PHYSICIAN'S NAME (Type) JORGE LABARRAQUE							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/13/59		22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		22d. LOCATION (City, town, or county) (State) Upper Marlboro Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Buns				ADDRESS Marlboro Md.		24a. REC'D BY REGISTRAR DATE AUG 11 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Frazer			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

